The Modern Hospital

AUGUST 1949

Can hospitals practice medicine? • Evaluation of rooming-in plan • F.C.C. rules on diathermy and television • Group practice in a small community • Hospitals under socialized medicine • Report on home care • Small hospitals

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The Modern Hospital

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AUGUST 1949

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AMONG THE AUTHORS

Dr. Elmer Hess is abundantly qualified to occupy his position as chairman of the American Medical Association's important committee on hospitals and the practice of medicine. He holds senior attending or consulting appointments on the staffs of seven hospitals in or near Erie, Pa., where he has practiced medicine since 1912. A graduate of the University of Pennsylvania Medical School, Dr. Hess served with the army medical corps in France in World War I and received a number of decorations from the French and U.S. governments. He is a member of the American Board of Urology, has been president of his county and state medical societies, and is a frequent contributor to medical journals. His article on page 86 of this magazine deals with medical-hospital relations.

Howard A. Carter is secretary of the American Medical Association's Council on Physical Medicine and Rehabilitation, a position he has held for 19 years. As secretary of the council Mr. Carter annually studies and reports on the effectiveness of a wide variety of devices, equipment and routines aimed at achieving therapeutic results by physical means. A mechanical engineer by profession, he has also been a teacher of physics and mathematics and has written a number of papers on hearing aids, audiometers, acoustics and electric current therapy. His article on page 64 of this magazine is aimed at providing authoritative information for hospital administrators about the recent F.C.C. ruling on diathermy wave lengths and television interference.

Lawrence R. Payne, who is now directing the Baylor University hospital system's multi-million dollar development program in Dallas, Tex., has been associated with the university hospital since 1932, with the exception of one five-year period (1938 to 1943) when he took time out to serve as administrator of the Hillcrest Memorial Hospital at Waco. A native Texan, Mr. Payne attended Hardin-Simmons University at Abilene, then spent five years in business before he took his first hospital job, heading Baylor's group hospitalization department—the infant that became Blue Cross. He became assistant superintendent of the hospital in 1935 and returned from Hillcrest in 1943 as administrator, the post he held until he took over his development responsibilities a few months ago.

Eli Ginzberg, whose series of articles on government hospitals and hospitalization programs continues in this issue (page 73), is professor of economics at Columbia University's school of business, a job he looks after when he isn't busy as chairman of the Committee on the Function of Nursing, director of the New York State Hospital Study, consultant to the Surgeon General of the Army, or consultant to the committee on Federal Medical Services of the Hoover Commission. Dr. Ginzberg's first contact with medical economics and administration came during the war when he set up and became director of the Resources Analysis Division in the Surgeon General's office. The contact took both ways, and he has been engrossed in medical administrative responsibilities ever since.

Reader Opinion

Bundles for Chile

Sirs:

The National Committee for Chile is now receiving gifts for the library of the medical school of the University of Chile at its new collection center in the Library of Congress, Washington, D.C. The newer materials in the library, including periodicals, books and reference materials, were totally destroyed in a recent fire. Medical periodicals of the last 10 years and recent medical books are urgently needed. Back numbers of your journal would certainly be appreciated.

National Committee for Chile
Room 318
Library of Congress
Washington, D.C.

Interns

Sirs:

Your March issue carried an article advocating that hospitals continue to carry out the intern placement plan and stated "A half loaf is better than none." When it comes to interns I feel that the plan is fine for the large teaching hospitals connected with medical schools and also for some of the big, outstanding hospitals. Under the plan, they pick the cream of the medical school graduates and because of their standing and prestige are generally assured their full quota. It is easy to see why Dr. Buerki and the group he represents would like to have it continued on the present basis. Let us consider the facts in the case:

1. There are about half the number of medical graduates of A.M.A.-approved schools as there are A.M.A.-approved internships available.

2. The deans of the medical schools instruct their seniors or prospective interns to take as first choice a hospital affiliated with a medical school. Second choice is a large, outstanding hospital in the section of the country where they expect to practice, and third choice is a hospital approved by the A.M.A. for intern training, where they are reasonably sure of obtaining an appointment.

The result, naturally, is that first and second choice, as recommended by the deans, take practically all the medical graduates. I do not see how you can blame the community hospitals for wanting to jump the gun and appoint some of the applicants before they are accepted by a teaching hospital.

Solution? There is no ideal answer as long as the supply does not meet the demand. We have been through a war where the supply did not meet the demand, and the only answer was rationing. Why not apply this principle to our intern problem? The Association of Medical Colleges can estimate closely the approximate number of medical graduates that will be available for internships, and the American Medical Association knows how many approved internships there are available in the hospitals. With this information it should be a simple matter to decide just how many internships would be permitted each hospital so they would all get a certain proportion rather than the large hospitals getting them all and the small hospitals getting none.

Maybe this sounds like a lot of griping, but I feel this same problem applies to almost all community hospitals all over the country unless they are hooked up with a medical school.

Ernest G. McKay
Superintendent
Tampa Municipal Hospital
Tampa, Fla.

Indigent Care

Sirs:

I agree with everything you have stated on payments for indigent care. The county now pays us $9 per day for general hospital care and $6.85 for tuberculosis, all-inclusive except for penicillin, streptomycin and blood. Our costs, based on the last six months of 1948, are $15.60 per day in the general hospital and $7.63 in the tuberculosis division. Beginning January 1, the county agreed to pay us 75 cents per visit for clinic visits, provided the patient is already on active relief.

Based on estimated patient days and clinic visits, we are losing about $225,000 a year on inpatients and about $25,000 a year on outpatients. This, of course, has to be passed on to the private and semiprivate patients paying their own way, and we have just instituted a

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$2 across-the-board increase in room and board charges which would not have been necessary had this money been forthcoming from the county.

It is high time this all ended.

Reader's Name Withheld

Not Practical

Sirs:

The April 1949 issue contains an article, "Drug Standards Save Money," by Dr. Bernard Krohn. The title is very true, but I would like to express the opinion that the suggestions made by Dr. Krohn would impair the treatment the patient receives in the hospital. They are not practical or possible in any but a very small institution.

Paul G. Bjerke
Pharmacist

Luther Hospital
Eau Claire, Wis.

Whole Truth

Sirs:

The article by Dr. Brian Bird, entitled "We Cannot Make Hospitals Out of Asylums," in the September 1948 issue of The MODERN HOSPITAL, was most welcome. But more is needed than was in that article. A thing is never settled until it is settled right.

My slogan for more than 14 years has been, "A state hospital is not a hospital, and never will be a hospital." The most powerful agency in keeping state institutions from having any resemblance to hospitals is that, to please those who pay the piper, they have allowed them to call the tune, meaning that in order to please families that are unwilling to give all their members loyalty, and officials, such as county judges, legislators, and, it seems to me, even governors, who want these people pleased because of their votes, the state hospitals have admitted and kept thousands of persons whom no honest or sensible person would want locked up.

Many of these are as normal-minded as anyone ever is, and many have only abnormalities of mind that are not incompatible with life outside. The late Dr. Irving S. Cutter said, "The harmless psychotic can function well in almost any community," and they have locked up not only people with harmless odd notions, but good, kind, amiable, useful, even superior persons with no odd notions.

Dr. Bird counts all the persons now locked up in the erstwhile asylums, as either acute or chronic mental cases. He says that 75 or 80 per cent of these are chronic cases. What are called chronic cases in state hospitals are mostly those who have never had any attention from any doctor, not even an initial examination, but are just pushed back into the discard and given the designation of incurable.

To give the persons now counted as patients in mental hospitals a square deal, it would be necessary for competent psychiatrists to take time to examine all of them, and a large percentage could be freed at once. Money now used to detain them wrongfully could be used for attending to this. In Iowa, in February 1947, Dr. Frank E. Leslie, employed by the Board of Control to investigate the institutions, reported to the legislature that a large number could and should be placed in outside employment. Not a thing was done about this.

Expensive court proceedings have been paid for to get some of these persons out, and large numbers more could be gotten out, in spite of the state hospitals' determination to keep them, if money were available to pay for court proceedings. The great medical and mental hygiene organizations, and most of the individual psychiatrists,

will not admit that there are such conditions. It is unworthy not to do so, not to face the facts, and insist on giving the people an honest deal. There would not be anywhere near 75 or 80 per cent of "chronic cases," if all those wrongfully shut up were freed. Many could step right out and live with relatives, or earn their own living, without going through any "adjustment." They could do this even after they have been locked up for years.

During the sensational exposure of the Boston State Hospital in 1937, the *Boston Post* had an editorial of which these are extracts:

"There is a widespread feeling, even shared by psychiatrists, that many persons are confined who really should be at liberty.

"Among the patients are men and women, mostly of advanced age, who are there because their families wish them stowed away so that the expense and responsibility of caring for them can be dodged. It is a comparatively easy matter to arrange for a commitment.

"It is doubtless true that many hundreds of persons in institutions could be safely released and relatives compelled to care for them."

No attention was paid to this by psychiatric authorities.

It should be said emphatically that large numbers of patients who are not old, some even very young and not mentally ill, are pushed by relatives into state hospitals.

Over and over I have referred to Rodney H. Brandon's effort, in 1941, when he was director of public welfare in Illinois, to get 7000 patients out of the state hospitals "for the mentally ill," and at least 1000 out of the two state hospitals "for the mentally deficient," who, he said, were wrongfully there. In the "Welfare Bulletins" he and the assistant director, the late Mrs. Mary L. Silvis, asserted that the state hospitals were crowded with people wrongfully taken and kept, and that this was preventing the proper treatment of those who really needed it. Mrs. Silvis said, "this situation must be changed." But it was not changed, unless getting worse was being changed. For several years there has been an actual boast that the population of the state hospitals was increasing by 1000 a year.

Real hospitals do not accept a family's diagnosis of illness. People do not try to get a member of the family into the Cook County Hospital on the claim that he has a broken leg or heart or lung disease, when they know there is no such ailment, for they know that immediate examination would expose their fraud, and they would have to take the person home in humiliation and defeat. But a person can be certified by two doctors, who usually know nothing of psychiatry, to be mentally ill "on the word of the family." One highly respected Illinois doctor told me he signs papers routinely, a county judge agrees, desiring to please the family, and the person is thereby "committed" to a state hospital. Often he has been taken entirely by surprise and not allowed time to get a single witness. In the state hospital, instead of examining him they pay no attention to him.

There is too much forcing of people in the name of psychiatry. In an article about the Day Hospital in Montreal, in The MODERN HOSPITAL not long ago, it was said that no one was forced to stay in either the day part of the hospital or the 24 hour part, and that forcing would prevent cure in some cases. The Special Committee of the American Bar Association on the Rights of the Mentally Ill said: "The way to a mental hospital should be as open as it is to a general hospital, so long as the way is open to leave," and that of all the bills pertaining to mentally ill persons and hospitals, which were introduced into the New York legislature between January and June 1946, none contained any provision relating to the discharge or release of patients, or for the administration of their property. It will be said that the time for discharge is a medical matter and should be left to psychiatrists. But when this is said, the fact is lost sight of that in no ordinary hospital is it compulsory to stay. The doctor may insist in the strongest way, but he does not force the patient to stay.

Of course, this whole situation hinges on the fact that, with nearly no psychiatrists or other trained personnel, a tremendous excitement about the need for mental treatment was created. The result was that people who could have had no psychiatric examination outside or inside have lost their liberty and all other constitutional rights; many such are still losing them, and many have lost life itself, as is shown by the death rates for years. Drastic measures are called for to stop this injustice. No suggestion for mental hospitals will work as long as it is planned to try to accomplish the impossible.

Edith G. G. Graff, M.D.
Greenup, Ill.

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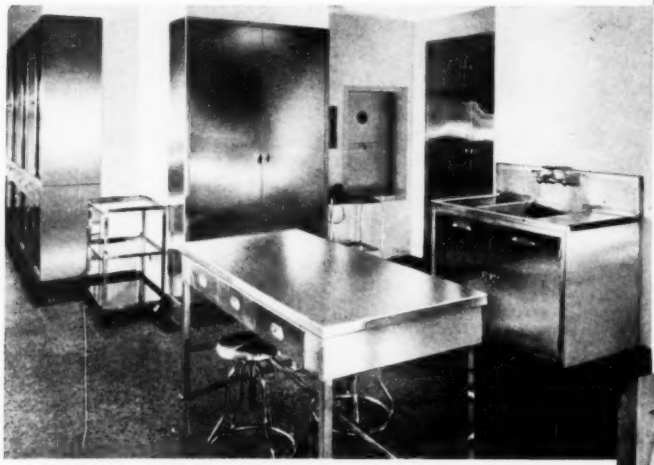
Above. STAINLESS STEEL GLOVE POWDERING BOX is shown here in use. Developed by Blickman designers, this Erie model provides a practical enclosed unit for powdering surgeon's gloves after washing.



Left. THE CENTRAL SUPPLY ROOM in St. Peter's Hospital, Albany, N.Y. functions efficiently with Blickman-Built stainless steel equipment. Note how recessed cabinets fit perfectly into wall spaces. Work table in foreground is designed so that nurses can work at both sides.

Below. STAINLESS STEEL COUNTERS with BUILT-IN SINKS—This is the receiving and cleaning section of St. Peter's Central Supply department. Stainless steel counters have sound-deadened work tops. Splash-back and work-top are integral. All corners, coves and intersections are fully rounded to facilitate cleaning.

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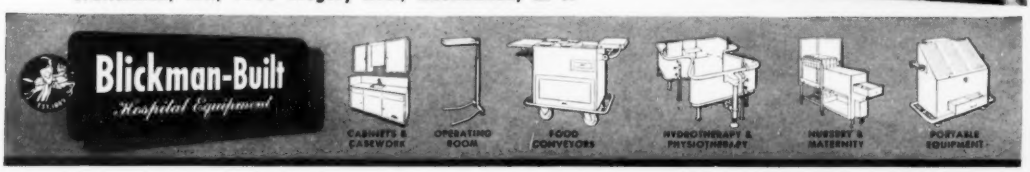

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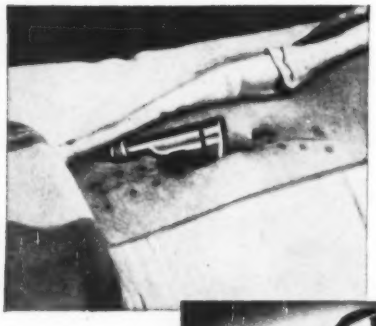

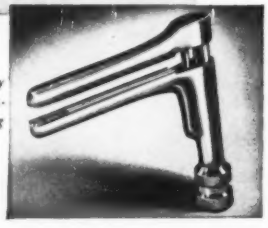

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* Surgery: Vol. 6, No. 3, 428-430, September 1939.

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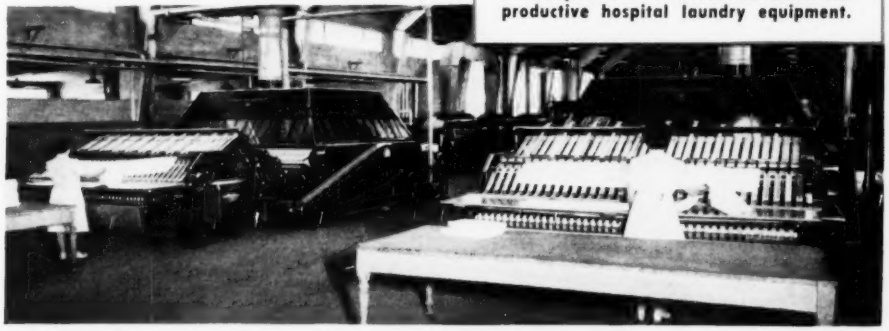

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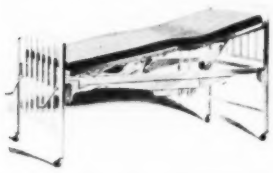

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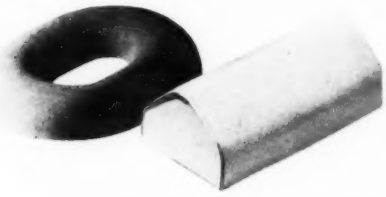

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The General Electric D-3 x-ray unit rolls easily to bedsides throughout the hospital. Correct weight distribution keeps it steadfast. Large rubber-tired wheels take it over sills and into and out of elevators.

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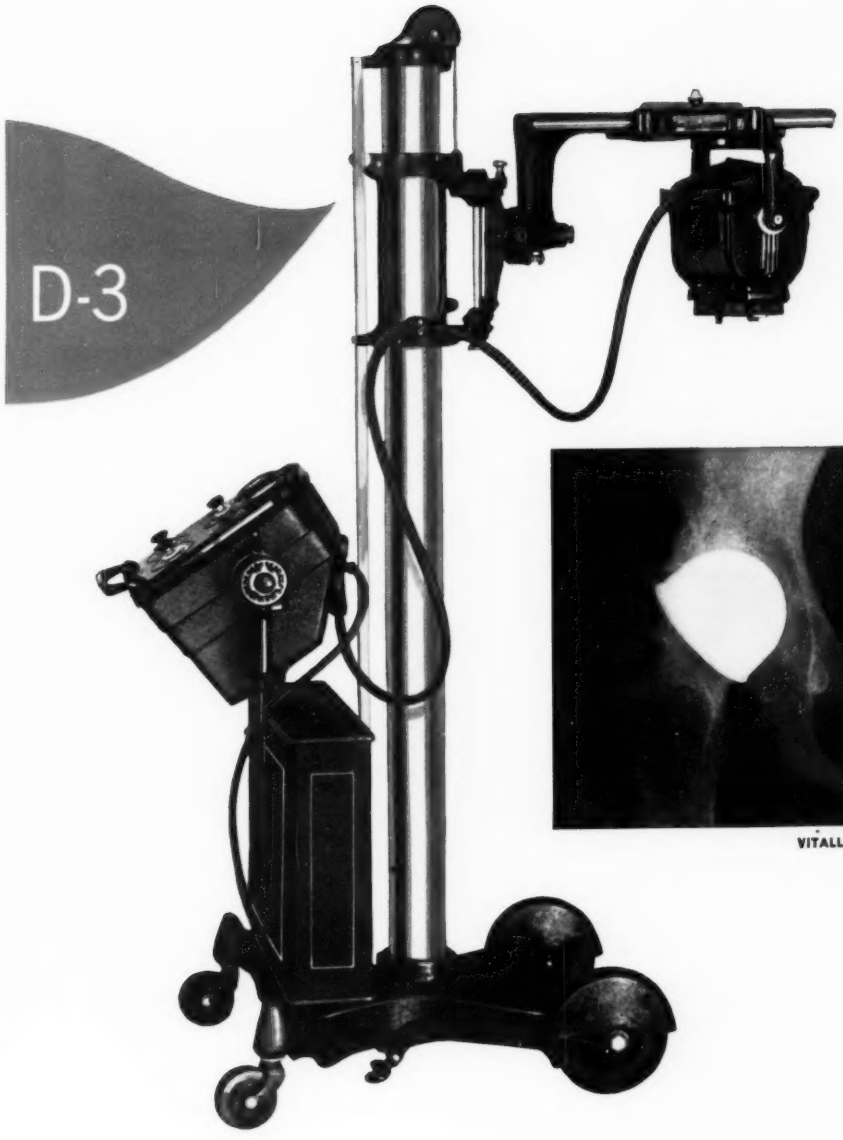
For fine detail. The D-3 has its own specially designed Coolidge tube with an exceptionally fine focal spot. Because the high-voltage system is oil-immersed, the D-3 is not affected by atmospheric conditions. A pre-reading filament ammeter allows the operator to preset the tube current. The D-3 is radiographically calibrated for 25 ma at 80 kvp or 20 ma at 85 kvp.

For fluoroscopy. The shutter arm contains all fluoroscopic shutter controls. Operator varies length and width of illuminated area on screen . . . can also control vertical and horizontal travel of the tube head. Fluoroscopic guard provides a minimum focal-spot-patient distance of 12 inches.

GENERAL ELECTRIC
X-RAY CORPORATION

General Electric X-Ray Corporation manufactures and distributes x-ray apparatus for medical, dental and industrial use; electromedical apparatus; x-ray and electromedical supplies and accessories.

FREE *You've no idea how helpful the D-3 can be – unless you have our handsome booklet on it. Write General Electric X-Ray Corporation, Dept. H-12, 4855 West McGeoch Ave., Milwaukee 14, Wisc.*



VITALLIUM CUP ARTHROPLASTY

THE PATIENT'S DOING FINE

with a

STANLEY

BEDSIDE COMPANION

Let the patients help themselves. They're sure to enjoy it with Stanley service. These graceful pitchers hoard liquid temperature for hours . . . keep beverages refreshing to the last sip. With a Stanley Vacuum Pitcher or Servitor to brighten the sickroom, constant refilling becomes unnecessary. Nurses are saved extra steps and precious minutes every day.

Stanley pitchers are easy to sterilize. Boiling water cannot harm the lining nor tarnish the cheerful chromium-plated outer shell. You're assured years of service and luxurious beauty with Stanley. Remember, "It will not break."

STANLEY

"IT WILL NOT BREAK"

Chromium-plated
VACUUM PITCHER
one quart
capacity

Chromium-plated
VACUUM SERVITOR
24-oz. capacity

- Crack-Proof and Chip-Proof, Nothing to Break
- Do not Require Replating nor Constant Polishing
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- All Seams Are Air-Tight, Water-Tight

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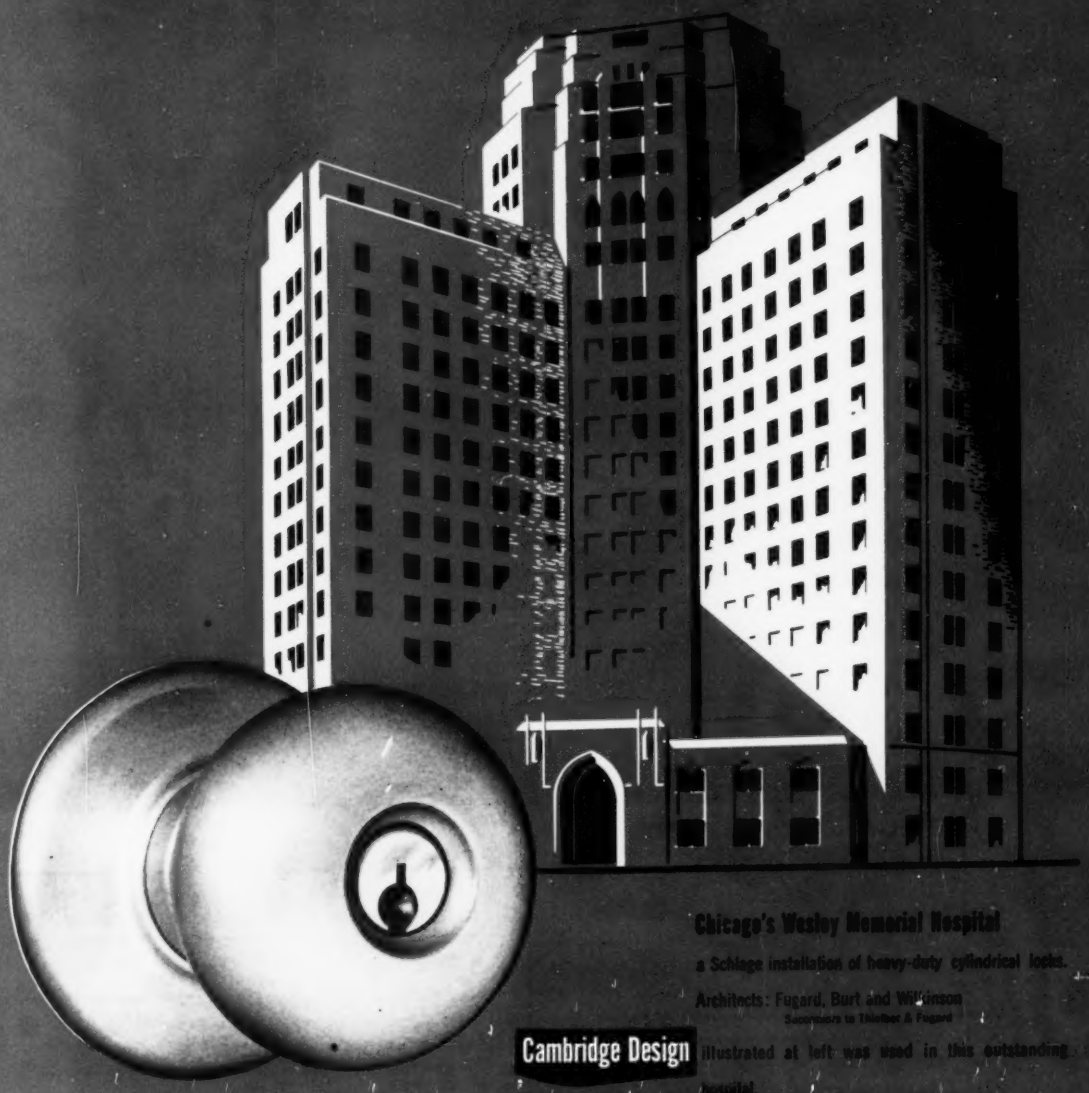
SCHLAGE ...first name in cylindrical locks



Chicago's Wesley Memorial Hospital

a Schlage installation of heavy-duty cylindrical locks.

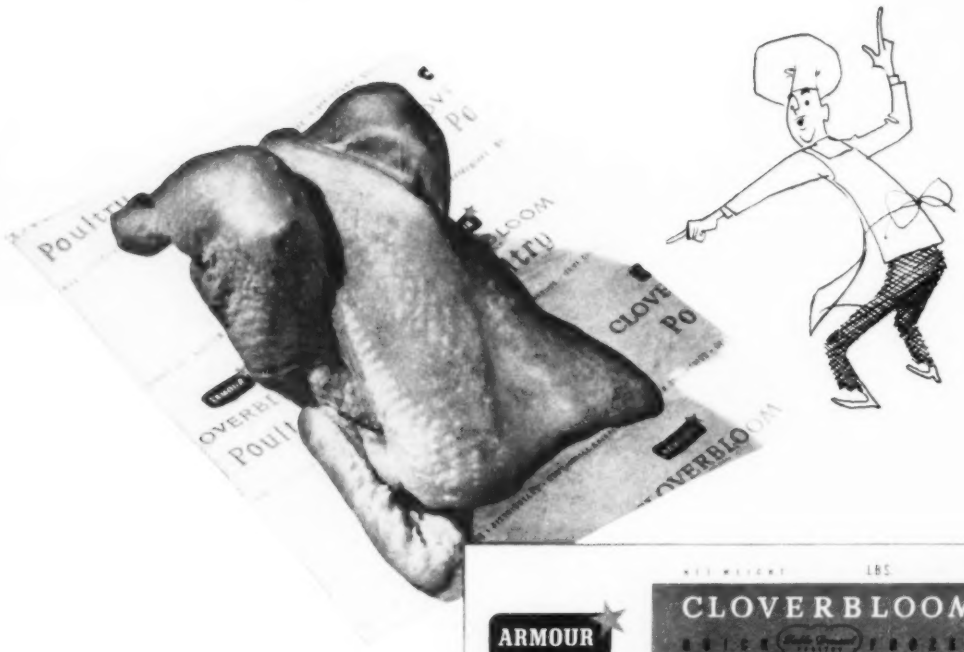
Architects: Fugard, Burt and Wilkinson
Successors to Thielbar & Fugard

Cambridge Design illustrated at left was used in this outstanding hospital.

SCHLAGE LOCK COMPANY

SAN FRANCISCO - NEW YORK

11 uniform sizes!



IN ARMOUR CLOVERBLOOM HOTEL-AND-RESTAURANT-PACK POULTRY!

Only Armour offers you such a wide range of weights and sizes—uniformity that means easily controlled portion costs and *equal* portions for all servings.

Cloverbloom Fryers and Broilers are processed from select *meat-type* birds only—quick-frozen and fully-drawn in quantities to fit your needs.

Yes, Armour's widespread procurement and distribution facilities can quickly supply you with *flavor-fresh* poultry anywhere in the 48 states—52 weeks a year.

The Chart at right will show you the wide range of weights available in Armour Cloverbloom Hotel-and-Restaurant-Pack Broiling and Frying Chickens. For a *FREE*, handy, Armour Cloverbloom Chicken Portion Cost Chart, see your Armour salesman or write to:

AVAILABLE WEIGHTS

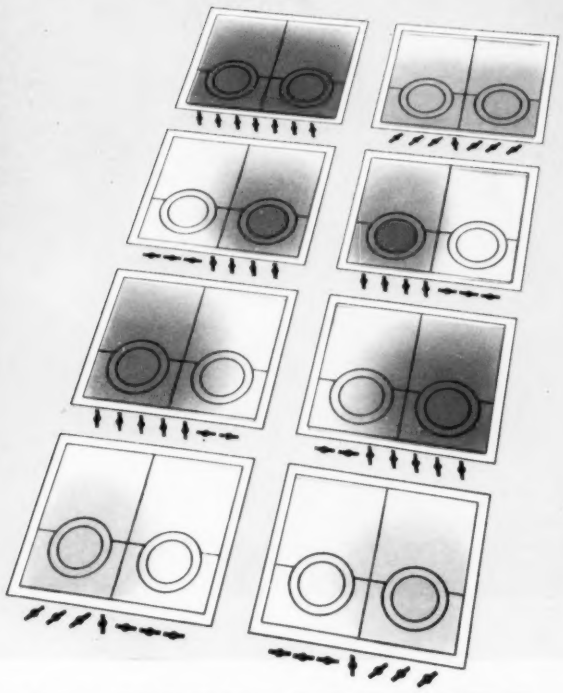
SYMBOL & CLASS NO.		N. Y. DRESSED WT. PER DOZ.	DRAWN WT. PER BIRD
	BROILERS		
H-01		17 to 18#	1# to 1# 1 oz.
H-1	Packed	19 to 20#	1# 2 oz. to 1# 5 oz.
H-02	6 Birds	21 to 22#	1# 4 oz. to 1# 5 oz.
H-2	(12 Halves)	23 to 25#	1# 6 oz. to 1# 7 oz.
H-03	Per Box	26 to 27#	1# 8 oz. to 1# 9 oz.
H-3		28 to 30#	1# 10 oz. to 1# 12 oz.
	FRYERS		
H-04	Whole	31 to 32#	1# 13 oz. to 1# 15 oz.
H-4	Birds	33 to 35#	2# to 2# 2 oz.
H-05	(6 Birds)	36 to 38#	2# 3 oz. to 2# 5 oz.
H-5	Per Box	39 to 42#	2# 6 oz. to 2# 9 oz.
H-06		43 to 47#	2# 10 oz. to 2# 15 oz.

ARMOUR AND COMPANY

Hotel and Institution Department
General Offices • Chicago 9, Ill.

ONLY GARLAND THE LEADER

gives you top heat flexibility like this . . .



because only GARLAND

gives you FRONT-FIRED BURNERS

Pictured here are only a few of the infinite number of heat variations you get on the Garland All-hot Top.

Seven, yes, *seven* individually controlled burners—all *front-fired* give the chef *any* heat he wants—*anywhere* on the cooking top. Garland helps the chef prepare better food—faster. Garland helps save fuel. Garland helps reduce the cost per meal served.

All Garland models are available in stainless steel and equipped for use with manufactured, natural or L-P gases. Consult your Garland Food Service Equipment Dealer. He is an expert advisor.

GARLAND* THE TREND IS TO GAS FOR ALL COMMERCIAL COOKING

Heavy Duty Ranges • Restaurant Ranges • Broilers • Deep Fat Fryers • Toasters
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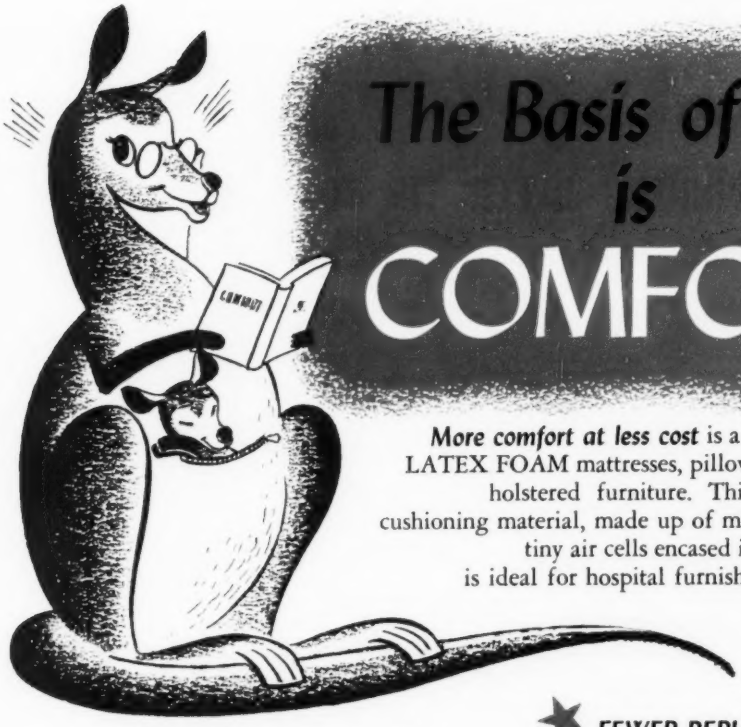

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More comfort at less cost is a big feature of LATEX FOAM mattresses, pillows and upholstered furniture. This amazing new cushioning material, made up of millions of tiny air cells encased in pure rubber latex, is ideal for hospital furnishing needs.*

GREATER COMFORT

soft, resilient, cool . . . proved more restful, less irritating to skin . . . no drag or pull to point of greatest deflection . . . perfect for patients with allergies.

FEWER REPLACEMENTS

retains its comfort and appearance indefinitely . . . cannot wear out, mat down, sag or lump.

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unequaled durability . . . even with severe usage, latex foam far outlasts any other cushioning material.

LESS MAINTENANCE

no deterioration and no dust, so it stays clean longer . . . mattresses, pillows and pads can be washed and sterilized.

LATEX FOAM *Cushioning*

in your hospital will mean greater comfort and cleanliness with less labor and less over-all expense

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*In addition to mattresses, pillows and upholstered furniture latex foam has gained widespread acceptance in hospitals for—

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1949 PRIZE WINNERS OFFER TIP TO DIETITIANS:

GENERAL FOODS QUANTITY RECIPES

SAVE MONEY AND MAKE PEOPLE TALK ABOUT YOUR FOOD

Mrs. Adamson, owner of the Royce Cafe, Edmond, Oklahoma, has used General Foods Quantity Recipes for more than five years.

"General Foods Quantity Recipes have won us priceless word-of-mouth advertising," says Mrs. Royce B. Adamson, 1st Prize Winner in General Foods 1949 Merchandising Ideas Contest.

"We use the recipes to make several of our 'specialties.' The results are always outstanding, and more important, always uniform. Thus our patrons get their favorite dishes the way they expect them. That adds up to repeat business. We also save money on food. The low-cost entree and dessert recipes help us prepare inexpensive dishes that look and taste exceptionally good."

"Keeps food costs down, too!" says Mrs. Frances Tegtmeier, Breakfast Menu Contest Winner.

"Keep food costs down? General Foods Quantity Recipes help us lick that problem. They've given us a menu-ful of ideas for low-cost entrees and desserts. The complete directions save us from using unnecessary amounts of ingredients. And we never have to waste good food testing new recipes. Best of all, we've received lots of compliments about these dishes."

PEOPLE WHO TALK ABOUT GOOD FOOD . . .

WHY GENERAL FOODS STANDARDIZED QUANTITY RECIPES CAN HELP YOU!

Whether you serve 5,000, 2,000 or 300 meals a day, General Foods Quantity Recipes can help you for these 4 reasons:

1. You get hundreds of recipes planned specifically for your type and volume of operation. New ones are mailed to you periodically.

2. You receive recipes for low-cost entrees, soups, salads, desserts, and quick breads.

3. Your recipe cards (designed for easy indexing) specify ingredients, proportions, cooking and serving directions, and other data.

4. Your General Foods Recipes give careful consideration to seasonal foods, ease of preparation, and other ingredient factors.

Millions of General Foods Quantity Recipe Cards are now in use. For this free service, ask your General Foods man, or write Institution Food Service, General Foods Corporation, 250 Park Ave., New York 17, N. Y.

Mrs. Tegtmeier and her husband own and operate the Bismark Cafe, Belleville, Illinois.

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Almost all General Foods Institution Products are packed with coupons you can redeem for scores of valuable prizes for hospital or personal use. Write today for your free prize catalog: General Foods Premium Dept., Battle Creek, Michigan.

TALK ABOUT GENERAL FOODS!

Martex® Fairfax®

towels • toweling • bathmats

AND NOW

NEW sheets and pillowcases

type 128—type 140

Ability to withstand brutal wear and to give long, satisfactory life in hard service is true of both MARTEX and FAIRFAX cotton towels and toweling. These sturdy quality towels are woven especially to assure economy in use.

The same ability to withstand hard wear is also true of the new, lovely but durable FAIRFAX sheets and pillow cases.

"MARTEX towels last so long they're economical."

Says the patient to her visitor—

"You know, I've learned something in this hospital that'll interest you."

"What's that?"

"That those lovely MARTEX towels you're always talking about are very economical."

"You mean this hospital uses MARTEX towels like I have at home?"

"They certainly do. The MARTEX label's right on them."

"But why does a hospital use MARTEX towels?"

"The superintendent of nurses told me experience proved MARTEX towels take brutal wear and punishment and lasted so long they were very economical."

products of **WEST POINT MANUFACTURING COMPANY**
WELLINGTON SEARS COMPANY, *selling agents*
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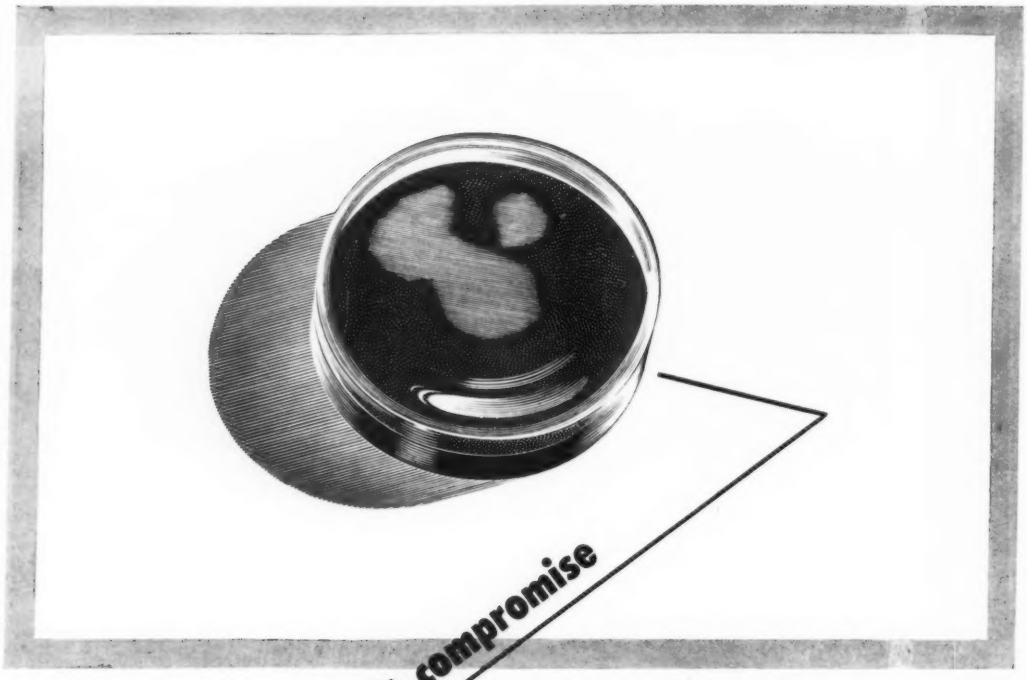
BOSTON CHICAGO DETROIT ATLANTA PHILADELPHIA SAN FRANCISCO LOS ANGELES NEW ORLEANS ST. LOUIS



Bacteria don't compromise

Nothing less than complete antiseptic action is satisfactory in surgical procedures. That is why such painstaking research preceded the development of Zephiran.

Pick any of the important attributes of a good antiseptic you want . . . prompt effectiveness, economy, safety . . . and you will find it in Zephiran chloride.

Zephiran chloride actually kills bacteria, it doesn't just inhibit them. It's fast in its action, too—faster than many other antiseptics. What's more, Zephiran is adequately germi*cidal* and less toxic than the mercurials.

For an antiseptic that is useful everywhere in hospital and office practice,
SPECIFY

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EFFECTIVE, SAFE, ECONOMICAL ANTISEPTIC

Supplied as: Aqueous Solution 1:1000, bottles of 8 fl. oz. and 1 U. S. gallon. Tincture 1:1000, tinted and stainless, bottles of 8 fl. oz. and 1 U. S. gallon. Concentrated Aqueous Solution 12.8%, bottles of 4 fl. oz. and 1 U. S. gallon (1 oz. = 1 U. S. gallon 1:1000 solution).

Zephiran, trademark reg. U. S. & Canada, brand of benzalkonium chloride (refined).

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NEW YORK 13, N. Y. • WINDSOR, ONTARIO

Neolithic Surgeon

SUTUREGRAM

NUMBER FOURTEEN IN A SERIES

Suturing Tissues Under Tension

When tissues are sutured under tension

(1) Either gaping occurs between sutures if tension is not great or —

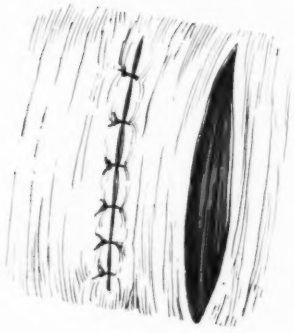
(2) Some of the sutures stretch between separated wound edges.

In both cases necrosis occurs where sutures hold tissues. Edges separate although sutures remain fully tied.

SUTUREGRAM

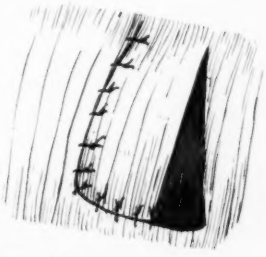
NUMBER FOURTEEN (CONTINUED)

Prevention of Separation



(a) Make release incisions on one or both sides or ——

(b) Swing flap of fascia



Defects left in fascia over intact muscles fill with scar tissue that later changes to resemble original fascia.

NEOLITHIC SURGEON—The earliest surgical operation of which there is concrete evidence is trepanning for the release of demons. Thousands of years before recorded history, as early as the Neolithic period, surgeons were performing this operation. Utilizing flakes of flint, they removed a small portion of the skull, about one inch in diameter, thus allowing the demon to escape. Numerous skulls found in France and other parts of Europe bear mute witness to the intelligence and skill of these early surgeons, and it is evident from bone growth around the trepanned holes that many patients survived.

let citrus fruits and juices

quicken convalescence with a smile!

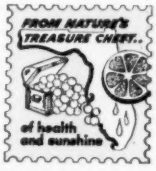
"The fact that practically everybody likes oranges..."[3] is particularly significant in the hospital dietary where high nutritional value, low cost, versatility and taste and eye appeal are paramount considerations. Few foods meet these criteria as fully as citrus fruits and juices, which supply such generous amounts of vitamin C, and other nutritional factors,* essential to bodily well-being.

A good hospital dietary can be made even better by the liberal daily inclusion of tangy, refreshing Florida citrus fruits and juices (fresh, canned, concentrated or frozen). Their extraordinary content of vitamin C, with an abundance of rich natural fruit sugars for quick energy—together with their positive role in improving calcium utilization, stimulating appetites, promoting mild laxation[2] and systemic alkalinization, and in the management of chronic infectious conditions[1]—make them worth their weight in gold as nutritional adjuvants for hospital patients of all ages (except where specifically contraindicated).

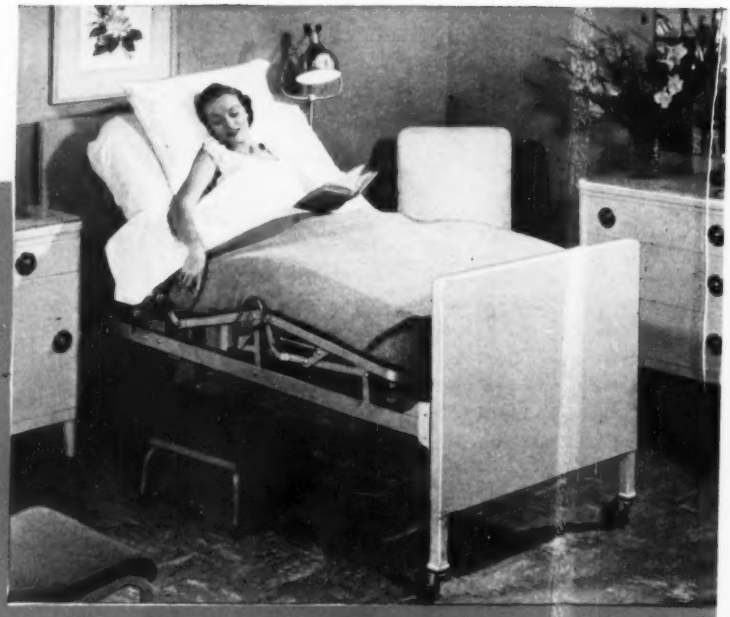
FLORIDA CITRUS COMMISSION
Lakeland, Florida

**Citrus fruits—among the richest known sources of vitamin C—also contain vitamins A, B, and P, readily assimilable natural fruit sugars, and other nutritional factors such as iron, calcium, citrates and citric acid.*

REFERENCES:
1. Gordon, E. S.: Nutritional and Vitamin Therapy in General Practice, Year Book Pub., 3rd ed., 1947. **2.** Rose, M. S.: Rose's Foundation of Nutrition, rev. by MacLeod and Taylor, Macmillan, 4th ed., 1944. **3.** Sherman, H. C.: Chemistry of Food and Nutrition, Macmillan, 7th ed., 1946.



FLORIDA
Oranges · Grapefruit · Tangerines



Eight different positions without help from the nurse—that's what the Simmons Self-Adjusting Bed makes available to your patients. With a simple manipulation of the bedside mounted levers, plus a shift of the patient's weight, a convalescent patient can gently ease the bed into more comfortable positions. Tension springs do the heavy work.

making new friends every day.

you'll like SIMMONS Self-Adjusting bed!...

● Simmons' revolutionary bed that helps patients help themselves—and relieves nurses, supervisors and administrators, too—is the hospital bed of the future. It is far more flexible than the standard two-crank bed—and it has no equal in convalescent wards and rooms. No wonder it is gaining in popularity every day. You'll like its many features, too.

If you are planning to equip a new hospital, or a new wing, or replace out-moded, uncomfortable beds, you will be wise to get the facts about the Simmons Self-Adjusting Bed and see it demonstrated. See your hospital supply dealer, visit any Simmons showroom or, write direct today to your nearest Simmons Company office.

To complete the patients' comfort, equip the bed with Beautyrest made expressly for hospitals. It gives patients firm, uniform support, and assures relaxation, so important during convalescence.

ADMINISTRATOR . . .
"Our FREEZ-A-BAG in operation paid for itself in 26 months"

NURSE . . .
"Every patient likes the FREEZ-A-BAGS so much better than uncomfortable ice caps"

DOCTOR . . .
"Cold therapy is more effective—the glycerin-filled bags are colder than ice"

ALL find FREEZ-A-BAG more economical, more effective than Ice Bags

After studying actual figures on their cost of providing cracked ice cold pack service, many hospital superintendents are turning to FREEZ-A-BAG service for cold therapy. Nurses and doctors, too, prefer this modern service to now-outmoded ice caps.

FREEZ-A-BAG eliminates the manufacture, purchase, storing, hauling and cracking of ice. Your nurses save many hours of time formerly used to prepare, fill and empty caps. Your patients find the soft, pliant, glycerin-filled bags far more comfortable. Bags freeze to a semi-solid at 11° F.

Ask your AMERICAN representative for detailed information, or write direct.

PLAN WITH AMERICAN
. . . the first name in hospital supplies

AMERICAN HOSPITAL SUPPLY CORPORATION

GENERAL OFFICES • EVANSTON, ILLINOIS

Your Surgeons Thank You For Almost Barehand Freedom When You

Specify **Rollpruf**

PIONEER

Surgical Gloves

They know that Rollpruf's sheerness gives them finger-tip sensitivity, that they always fit smooth and snug. That's why more and more surgeons are asking their surgical buyers to specify Rollprufs.

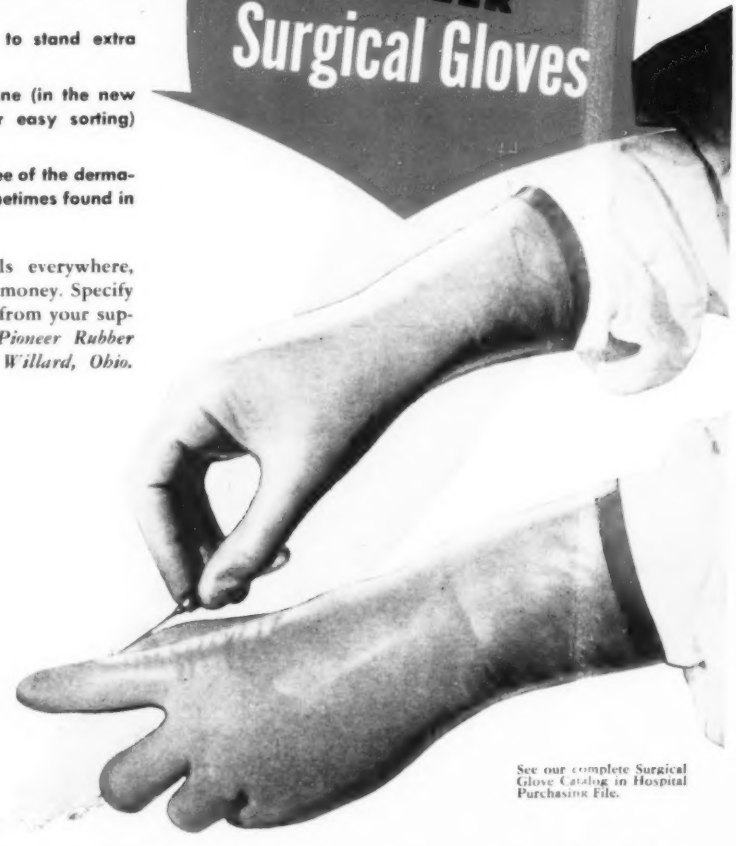
There are other reasons, too:

- **Rollpruf's flat-banded cuffs won't roll down and annoy during surgery.**
- **Banded wrists also reduce tearing—add to glove life.**
- **Rollprufs are processed to stand extra sterilizings.**
- **Made of DuPont neoprene (in the new hospital green color for easy sorting) or pure latex.**
- **Neoprene Rollprufs are free of the dermatitis-inducing allergen sometimes found in natural rubber.**

Adopted by many hospitals everywhere, Rollprufs are more for your money. Specify Rollprufs — insist on them from your supplier — or write us. *The Pioneer Rubber Company, 750 Tiffin Road, Willard, Ohio.*

Pioneer Skin-Finish Rollprufs — made of latex rubber, new skin-soft texture. Non-slip finish on fingers adds remarkable new sureness to surgeon's touch. Flat-banded cuffs — no roll down.

Pioneer Autopsy Gloves—durable comfortable lightweight neoprene gloves. Non-slip finish for greater dexterity. Free of dermatitis-inducing allergen sometimes found in natural rubber.



See our complete Surgical Glove Catalog in Hospital Purchasing File.

PIONEER *Surgical Gloves*

★ The Result of Over 30 Years of Quality Glove Making ★

Small Hospital Questions

Progress of Standardization

Question: Has the standardization of articles, such as needles, proved successful or have items been standardized as far as they should be?—M.W., Iowa.

ANSWER: The American Hospital Association committee on purchasing simplification and standardization has been working for 15 years on the simplification and standardization of various important items in the hospital field. When the American Hospital Association decided to put a full-time purchasing specialist on the headquarters staff, the work of simplification and standardization received a great impetus. The reader is referred to an article on simplification and standardization which now appears in each edition of the *Hospital Purchasing File*. These articles are always written by William Braithwaite of the National Bureau of Standards, and the current chairman of the American Hospital Association committee. The items on which simplified practice or consumption standards reports have been issued are always listed in this *Hospital Purchasing File* article. Hospitals have a long way to go in putting into effect the splendid reports issued by the American Hospital Association committee and the National Bureau of Standards.

Hiring Specialists

Question: Should the hospital administrator be in the position to hire and fire, at his discretion, any pathologist, radiologist or anesthesiologist?—B.C., Minn.

ANSWER: When engaging the services of a pathologist, radiologist or anesthesiologist, it has been our policy to invite a subcommittee from the medical staff to review the applications and qualifications of the candidates with the administrator. At a personal interview with the selected candidate the same committee should attend a joint conference with the committee from the hospital board of trustees and the administrator. The administrator, however, should make the final contact with the candidate.

In regard to the "firing" of a staff member, I suggest that a formal written complaint be filed by the administrator with the same type of joint committee. The committee's decision should be in writing and filed with the board of trustees, and notification of the decision should be given the staff member over the signature of the secretary of the board. Proper consideration in the selection of applicants for such important positions will eliminate this problem. —WILLIAM B. SWEENEY.

Who Signs the Check?

Question: In the small hospital, who is generally responsible for approving bills for payment and signing of checks?—A.S., Me.

ANSWER: The superintendent of the small hospital is usually responsible for approving bills since he is usually the person who is responsible for the buying. However, it is true that in many small hospitals the superintendent not only approves bills but also signs checks. This practice should not routinely be encouraged—although it is a convenience and a privilege—as it might create doubt as to his honesty.—JEWELL W. THRASHER.

Full-Time Anesthetist

Question: Does it pay to have a full-time paid anesthetist in a small hospital?—R.A.P., N.J.

ANSWER: This is a rather difficult question to answer, inasmuch as the approximate size of the small hospital has not been specified. In a hospital of 50 beds or more, I would think that it would pay to have a full-time nurse anesthetist. In a hospital up to 75 beds, I am quite certain that a full-time nurse anesthetist would work out advantageously. As a matter of fact, if a large amount of surgery is done, it would be better to have two, as one must consider days off, alternate night calls, and vacations.

When a hospital has more than 75 beds, then a full-time, certified anesthesiologist will work out advantageously, not only from the hospital's standpoint, but from the patient's and doctor's as well. With almost 1000 different types of anesthetics now in use, the profession of anesthesiology is a highly specialized one. In my opinion, it is the job of the anesthesiologist to choose the type of anesthetics that should be given, as he has been trained for this job. In a small hospital, he can also be placed in charge of oxygen therapy and can direct the administration of transfusions and other types of intravenous therapy. I administer a hospital of 75 beds and we have a full-time anesthesiologist and nurse anesthetist.—A. A. AITA.

Compensation for Extra Work

Question: In a 60 bed hospital a nurse anesthetist is employed with dual responsibilities—those of a nurse anesthetist and, when a physician conducts the anesthesia, those of a scrub nurse. Should she be paid (a) a salary, (b) a salary and commission, or (c) otherwise?—E.F.C., Mass.

ANSWER: Since, more than likely, all the other nurses are on a straight salary, irrespective of the various duties, I believe it would be only fair that the nurse who has specialized in anesthesia should also be on a salary. She could very well be compensated additionally on a fee basis for night, Sunday and holiday work and this would not cause too much dissension among the other nurses. —A. A. AITA.

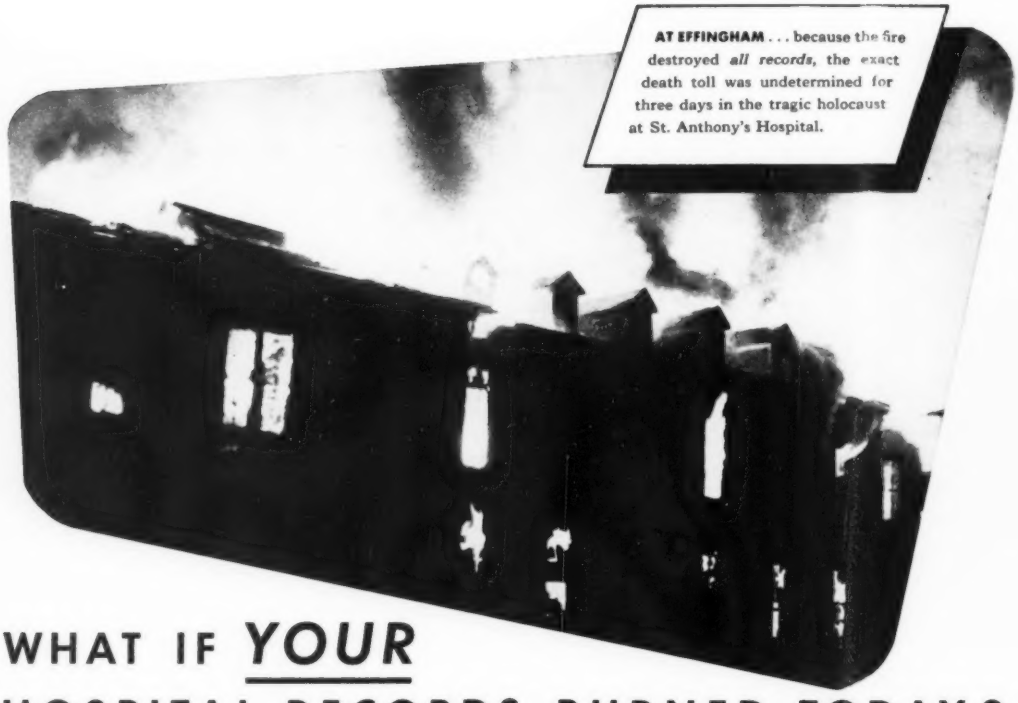
Signal Systems

Question: In planning for a new small hospital, what type of signal system for patients' use would be most economical and efficient and require a minimum amount of maintenance?—P.F., Me.

ANSWER: The bedside push button, lamp signal with audible buzzer provides an economical system for a small hospital. The installation should be free from other apparatus or wiring systems. Provision should be included for an emergency line from the accident room, obstetrics and surgery.

If finances permit consideration should be given to the two-way voice communications system, which is a step-saving method for the nursing staff.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.



AT EFFINGHAM . . . because the fire destroyed *all records*, the exact death toll was undetermined for three days in the tragic holocaust at St. Anthony's Hospital.

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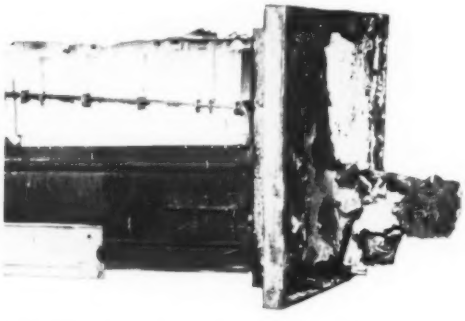

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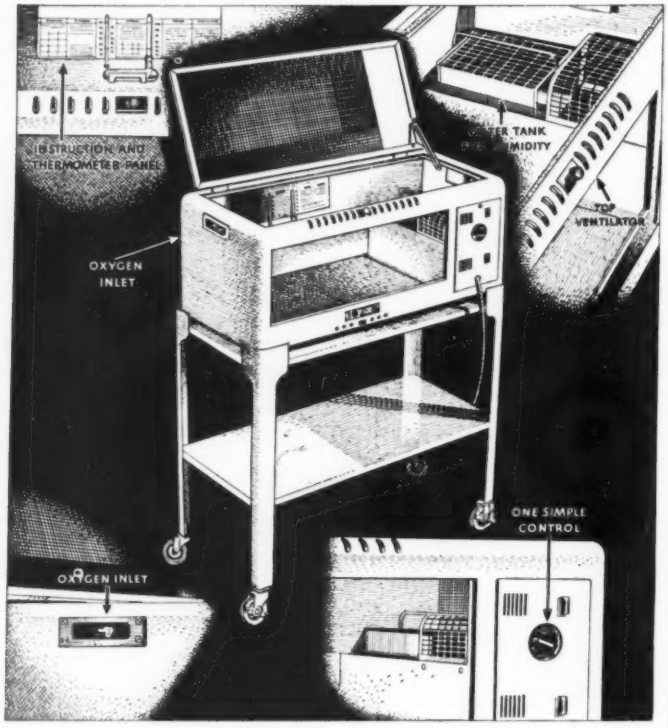

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Looking Forward

Cruising Down the River

AS THE business barometer alternately rises and falls inversely with the blood pressure of the nation's businessmen, the nasty suspicion keeps recurring that just about at the time all the nice hospitals now being built are finished, the bottom may drop out of everything and nobody will be able to afford hospital care. Administrators with long enough memories know what happens then; doctors and hospitals go begging for patients, and sick people go begging for medical and hospital care. As depression deepens, the economic barrier that separates a few people from proper medical care all the time moves over and cuts off larger and larger segments of the population.

Probably there is no sure way to avoid depression in a free, or part free, economy, and thus there is no way to prevent the hardship and disruption that come with depression. If the barrier is pushed back so that the smallest possible slice of the population is cut off when times are good, however, there should be just that much less hardship when times are bad.

The Hill Bill, providing aid for indigents through voluntary prepayment plans, appears to offer the best means of pushing the barrier back without giving the government too much authority on both sides of it. It might be well to add a feature which has already been suggested, making the amount of subscription payments to voluntary plans vary with the income of the subscriber. If control is effectively decentralized, it should be possible to permit free movement of families from self-help to public-aid status and back again with changing times—another desirable feature.

Equally important with these efforts to make certain that our hospitals will never be empty for lack of patients are steps to make sure that our new facilities will be adequately staffed. It seems unlikely that medical and nursing education can be expanded using their own diminishing resources; some form of public aid may be necessary to ensure the presence of doctors and nurses at all the bedsides. Here, again, decentralized administration and professional rather than political control are the needed safeguards; operation of the Hill-Burton Act under Dr. Hoge and his staff is reassuring proof that these can be had in a federal aid program.

There are some people who regard any form of federal aid as socialistic and undesirable. A leading medical journal, in fact, recently accused a doctor who has actively sponsored the Hill Bill of "selling us down the river of socialism from the inside." This may be true. But the fact is that we're bound down river anyway; by acting now, hospital and medical people can take the wheel themselves. The other choices would seem to be trying to swim upstream or lying in the bottom of the boat cursing while the bureaucrats and politicians steer us onto the rocks.

The Light and the Dark

UNDER the chairmanship of Dr. Elmer Hess of Erie, Pa., the American Medical Association's committee on hospitals and the practice of medicine presented a report at the association's annual convention at Atlantic City in June that every hospital administrator and

trustee should study with care. The report was published in the *Journal* of the A.M.A. for June 18; a synopsis of it appeared in the July MODERN HOSPITAL. In general, it contained three significant recommendations affecting hospitals: (1) that hospitals should be bound by the same ethical considerations that govern the professional conduct of the individual physician; (2) that differences between hospitals and physicians (*i.e.* chiefly, radiologists, pathologists and anesthetists) should be referred to state medical society committees on hospital relations for adjudication when local discussions fail, and (3) that the judicial council of the A.M.A. should order withdrawal of A.M.A. approval from hospitals found guilty of unethical conduct.

The precise nature of unethical conduct on the part of a hospital was not defined in the report, but the language left little doubt that it would be considered unethical for a hospital to earn more revenue in its medical departments than is actually spent in the operation of those departments. Many hospitals have long been accustomed to using such revenues to help support other hospital activities; this is referred to as "profiteering" or "exploiting the physician" by some militant medicoes. The practice is neither logical nor desirable, perhaps, but unless the physician involved is underpaid compared to others practicing in the same community, it would seem to be not he but the patients who are being exploited, if anybody is. In any event the present report has grave implications for such hospitals, which may now be faced with a choice between loss of needed revenues and loss of valued A.M.A. approval.

These hospitals, particularly, will welcome the article by Dr. Hess on page 86 of this magazine. Written especially for The MODERN HOSPITAL audience, the article shows that Dr. Hess, at least, has a sympathetic understanding of the hospital's position in these professional problems. While he doesn't deal here with the important matter of revenues and costs, he does speak up strongly on two fundamental points: He makes it explicitly clear that the hospital is not "practicing medicine illegally" when it employs physicians on salary, and he acknowledges that their peculiar position as consultants to other physicians sets these specialists apart from their professional colleagues in a fashion that cannot be ignored.

Dr. Hess' article will not make friends for him in the militant set, but hospital people will applaud his fairness and courage. His attitude should diminish some of the apprehension that the report of his committee has created.

There's Doom in Those Bills!

THERE is no such thing as free hospital care. Somebody always pays for it. In the case of indigent patients who can't pay for themselves, the somebody is generally supposed to be an agency of local, county or state government. The fact that these agencies frequently don't pay enough means that somebody else has to pay too much. Usually, the somebody else turns out to be a lot of people who think hospital bills are too high. This unhappy circumstance could easily wreck the system.

It is encouraging to find more and more hospital people recognizing the potential doom in their financial statistics. In a report published recently, for example, the president of the Royal Victoria Hospital at Montreal took grave note of the fact that "the Provincial Government has not seen fit to increase the daily allowance for indigent care. The cost of such care in our public wards was $9.95 per day and the amount received under the [Quebec Public Charities] Act was only $4 per day. It will be seen, therefore, that this hospital is bearing approximately 60 per cent of the financial burden."

After stating the facts, the president read the signs. "This voluntary hospital cannot long survive under the heavy deficit conditions of recent years," he declared bluntly. "There must be an equitable sharing of the burden by the patient, by the agencies of government and by private donations. Until these costs are more adequately borne by the public authorities, projects for building new hospitals with public funds, laudable as many of them appear to be, should be carefully considered [to determine] if after completion there is to result a further drain on private resources in order to meet more operating and maintenance deficits."

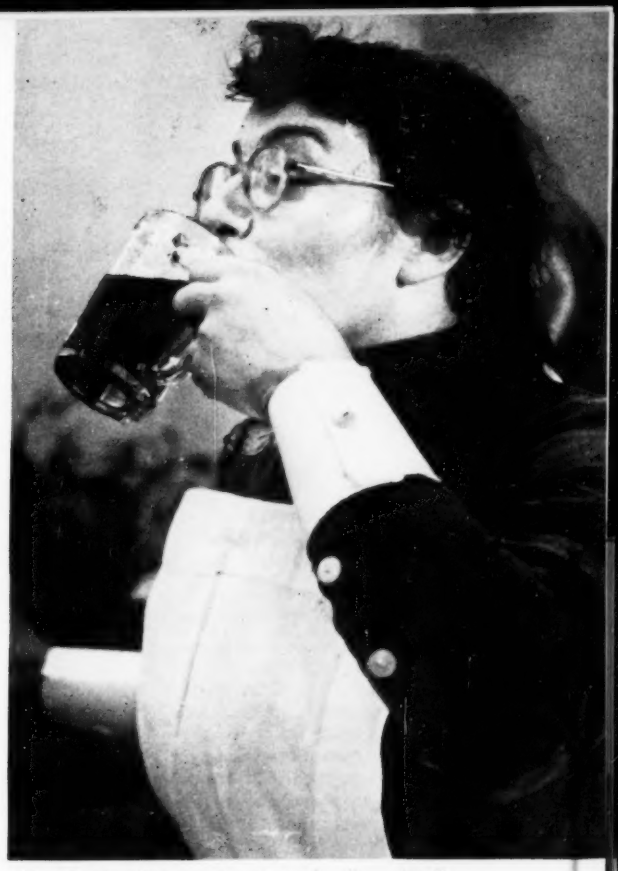
In a recent communication to the State Crippled Children Commission, the Michigan Hospital Association has stated the case for hospitals in similarly plain terms: The average cost of caring for crippled children in Michigan hospitals was $14.75 per day. The average payment from the commission was $8.63. The loss was $6.12, or 40 per cent. In the aggregate, Michigan hospitals lost hundreds of thousands of dollars in the operation of the crippled children's program in 1948, it was reported. Asking the governor for a full review of the hospitals' case, the association pointed out that hospitals are not bound legally to accept state cases for less than cost.

"Morally, however, hospitals cannot refuse care to the emergent sick," the association said, "even if the cost of that care is ruinous. The question is then, can hospitals keep up this pace? If they are forced to do so, it will ultimately mean substandard care, insolvency, or both. There is no place for involuntary charity; the hospitals' existence is jeopardized by passing the burden to the already overcharged patients of the community. The least the State of Michigan can do is support the voluntary hospital program, which, it has been demonstrated, can perform the job more effectively than it could be done if the state were to construct and maintain its own hospitals."

In many other communities, hospitals are finding and bringing similar facts to public attention. Administrators and trustees who press vigorously for adequate payments in their own communities and support federal legislation seeking to put indigent financing on a stable basis through voluntary prepayment plans are doing all that can be done today. Without their sustained efforts, the system is bound to crash.

HOSPITALS UNDER SOCIALIZED MEDICINE

Continuing a study of the hospital system in England under the British National Health Service



This British hospital nurse is enjoying her "amenities" at a hospital party. With pay standardized under the Health Service Act, hospitals are emphasizing recreation programs for nurses and other employes.

R. M. CUNNINGHAM JR.

THERE are many ways of judging a doctor's skill, but as far as the public is concerned the final measure of his work is the result. If the patient improves, the work is good; if he does not, it is bad. While the application of this crude yardstick may do the doctor an injustice in certain cases, it may favor him in others, and, in the long run, it is probably as fair a method as can be found. It seems logical, therefore, that a medical system or plan should be judged on the same basis—by the results it gets rather than by any preconceived or theoretical standard.

Obviously, it is too early yet to tell whether the health of the British people is improving or worsening under their National Health Service, which is just a year old. Thus the arguments that are raging about the service in Britain are comparable, in a way, to a dispute about the method of treating a patient whose life is still in the balance. Neglecting the whole organism, both parties to the dispute can find numerous symptoms that seem to support their divergent theories. Until the outcome is conclusive, the rightness or wrongness of their views can only be a matter of individual preference—a circumstance that should be kept in mind by the observer who is working his way through the Grand Right and Left of fact and opinion about the British National Health Service.

Because of the keen interest that American doctors and hospital administrators have shown in the British program, it seems important to emphasize two fundamental points that have commonly been overlooked in our discussions of socialized medicine —first, that the success or failure of the British plan must be viewed against the background of British hospital and medical standards rather than our own, and, second, that any conclusion one may reach about the British program

Nurses take time out for coffee in the employes' lounge of the Canadian Memorial Red Cross Hospital at Taplow, England.

does not necessarily apply to the United States; differences between the two countries, medically speaking, are broad enough so that what is right for them might be wrong for us.

Compared to the United States, for example, Britain has been seriously under-doctored. In England and Wales, where the new program is now operating, the ratio of doctors to population is 1 to 2300, against our own 1 to 1100. Assuming that the medical profession of both nations is competent and conscientious, it is obvious that concepts of adequacy in medical care must be vastly different on opposite sides of the Atlantic. The nature of the difference is suggested in the comment of an Englishwoman who grew up in a family of comfortable means. "We never thought of calling the doctor except when Granny died or Mother had a baby," she said.

FOR WAGE EARNERS ONLY

In families of lesser circumstances it has often been common practice to call the doctor only for the wage earner—partly because his health is a matter of vital concern in the family's struggle for existence, and partly because the wage earner, but not members of his family, was protected under the old National Health Insurance scheme that preceded the present service. In the poorer industrial districts, advocates of the new system maintain, the general practitioner is now for the first time a family doctor in the true sense, since he is looking after the wives and children as well as the workers of his neighborhood.

This fact has little meaning, however, until one knows what kind of care the family is getting. Obviously, if it is true to any considerable degree that dependents are getting medical care for the first time under the new plan, it must have added a considerable load of work on Britain's already overburdened doctors, and it may be fair to question the quality of service they can render under the circumstances. Critics say that the plan penalizes the doctor with a professional conscience. "I was called out of bed the other night to attend a new patient," a general practitioner related not long ago. "It turned out he was suffering from acute retention and needed catheterization. During the course of my visit I asked him if he had had that kind of difficulty before, and what had been done about it.

"'Oh, yes,' the patient told me, 'it happened just a few months ago, when we were living in London. I sent the Missus over to get the doctor. He was in bed, but his wife answered the door and asked what the trouble was. They talked back and forth for a few minutes, then she went and told the doctor, and he sent us a paper to take along to the hospital for special treatment.'

"I got up and drove six miles and treated the patient," the general practitioner concluded. "The doctor in London stayed in bed and gave his wife a piece of paper to give the patient's wife. Under the National Health Service, we both got paid the same."

It can be argued with some force that experiences of this kind will in time discourage the doctor from putting forth his best professional efforts. A state medical service tends to level off at mediocrity, it is maintained; the doctor puts on his hat and goes home at 5 o'clock like any other bureaucrat; the spirit that has distinguished his profession is submerged, and finally vanishes.

WORK WON'T SUFFER

Actually, this line of reasoning does the profession an injustice, since it assumes that the doctor is motivated primarily by the desire for financial gain. Like everyone else, of course, the doctor has to live and wants to live comfortably, but there is no good reason to believe that his professional work will suffer if the opportunity for extra financial reward is limited. The idea that the salaried doctor is in some way of lesser professional stature than his colleague in private practice has fewer adherents in Britain than in the United States, where this quaint notion is still widely held. "I have been in a full-time, salaried position for fifteen years, and many of my colleagues here are full-time men," a distinguished specialist at a London hospital told a visitor recently, "and I have neither experienced nor observed any falling off in energy or initiative as a result. If anything, the reverse is true, as contributions to the scientific literature would indicate. The number and quality of the men applying for full-time staff positions here have gone up steadily during the period of my association with this hospital. Medicine itself presents such a challenge that if the best type of man is given adequate facilities to do his best work, it is comparatively uninfluenced by the type of compensation he receives."

While private practice is continuing

in England for patients who have the means to pay and doctors who have the energy and inclination to serve them, there can be no question that the National Health Service is moving in the other direction. Specialist services, for example, are provided through the hospital, either by full-time, salaried staff members or by part-time consultants whose pay is established on a national scale. For the moment, this arrangement favors the young specialist, who is now earning a salary at an age when his predecessors were going in debt to get started in private practice, at the expense of older men who borrowed money to finance their specialty training in anticipation of substantial earnings which are now largely denied them. Once the adjustment to the new method is completed, however, health service supporters insist that the arrangement should be reasonably satisfactory all around. Among other benefits, they say, it may offer the patient some measure of protection against the surgeon whose inclination to operate is fiscally as well as medically inspired, and it may protect the specialist against demands on his time by patients who diagnose their own ailments and sidestep the general practitioner. So far, it is added, no evidence has appeared in the operation of the hospital specialty service to indicate that there will be any bureaucratic or lay interference in professional matters—one of the dreaded bugbears of a state service.

Acknowledging that the technical sin of lay interference may have been avoided, some doctors nevertheless insist that their professional freedom is gone with the administrative wind. This is the view of the tuberculosis specialist who requested streptomycin for a patient and had to get half a dozen endorsements ("All by laymen," he reminded a visitor) on the application before his request was granted.

Most such stories are exaggerations, if not downright lies, government spokesmen reply, denying that the system impinges seriously on the doctors' precious professional prerogatives. While it is plain that the government must exercise some practical control over conditions under which certain medical procedures are carried out, the distance between this necessary control and actual bureaucratic management of medicine is probably not measurable yet. Most doctors think it is alarmingly short.

Whether the next generation of doctors will be better or worse on account of the National Health Service, however, is obviously a matter of opinion rather than fact, and the answer may never emerge clearly. In assessing what is likely to occur as a result of generally leveled incomes for doctors, it should be borne in mind that the same thing is happening in other phases of British life. Through share-the-wealth taxes and nationalization programs, the doctor's friends in business and industry are facing the same restrictions of earning opportunity that have come to him.

It is British society, and not just the doctor's position in it, that is changing. There are many who think that in making these changes Great Britain is destroying the tree to prune the rotten branch, and they may be right. In any event, the person who seeks to judge the significance for America of Britain's National Health Service must consider whether our own social tree needs pruning as badly as theirs did.

ADMINISTRATOR UPGRADED

For whatever ultimate social purpose, British hospital administrators are taking their place in their newly nationalized industry with less dislocation, on the whole, than the doctors have experienced. In some 375 cases, at least, the immediate effect of the Health Service Act has been upgrading for the hospital administrator; these are the ones who are now secretaries of Hospital Management Committees—responsible for the operation of groups of hospitals under the new program. What has happened to administrators within the committees varies from group to group. Some of those who moved up to committee status were replaced by junior men who had been their assistants or deputies; others took their authority along to committee headquarters with them, leaving only glorified clerks in their places. Since management by committee under the new order is also inevitably to some extent management by regulation, administrators may exercise their judgment and initiative today only within stated limits. The bureaucratic yoke, of course, hangs heaviest around the necks of older administrators whose authority has been curbed the most. Among the younger men there is a noticeable disinclination to talk about the merits or demerits of the health service; their attitude is uniformly one that takes the view, "We've got it, now let's make it work"—a spirit that holds considerable promise for the future.

While most of the Hospital Management Committees are occupying space in one or another of the hospitals in their groups, there has been a tendency in recent months for committee staffs to locate in separate offices; several committees, for example, have bought or leased large country houses, residences of the erstwhile rich who have retreated into cottages or apartments. This practice is viewed with dismay by many hospital administrators for whom it foreshadows the development of a hospital bureaucracy that will have no direct contact with the hospital world as such. "I wouldn't take a management committee job at any salary," declared one administrator who has, in fact, turned down several committee appointments offering more money than he makes at his hospital. "I'm in hospital work because I love it and it's where I want to be," he explained. "As a hospital civil servant, I'd be indistinguishable from the railroad civil servant or the coal civil servant. I want no part of it for myself!"

That such fears may be justified is perhaps indicated in the remark of another hospital man, an able young executive who has become a committee secretary and is making rapid progress toward the development of an integrated group hospital service. Contemplating the administrative problems that lie ahead, this man said not long ago that he saw no reason why each hospital in a group should have its own administrator. "As I see it," he prophesied, "hospital people in the future will be mostly specialists—in accounting, catering, stores, purchasing or some other aspect of the administrative field. Each committee will have these functional executives to look after their operations in all the hospitals in the group, probably working with local committees and department heads. In that picture there is no place for the general administrator except at the committee level, or possibly in the very large hospitals."

The response to this kind of talk may be either an approving nod or an involuntary shudder, according to the individual concept of efficiency in hospital service. At any rate, it is unlikely that any such glistening administrative machines will be developed in the near future; like any other system, the British hospital serv-

ice must get along as best it can for the time being with the talent that is available. Meanwhile, the steps that are being taken toward group management probably represent less of a change for the hospital executive in England than they would in the United States. Voluntary hospitals there have long been accustomed to active rule by "house committees" which have generally had closer contact with the hospital and more direct management authority than is common among our voluntary boards of trustees—the American equivalent of the house committee.

LITTLE OR NO CHANGE

For reasons that vary according to who is reporting them, house committee rule is maintained with little or no change under the new system in hospitals that have been designated by the Minister of Health as teaching centers. Whether this was done to preserve academic freedom, as Ministry spokesmen maintain, or to soften the opposition of influential governors, administrators and doctors at the teaching hospitals, in the more cynical view, teaching hospitals have not felt the procedural effects of the new program except in a minor way, a circumstance that the rest of the hospital world regards with some resentment. In contrast with other voluntary hospitals whose accumulated funds have vanished into the financial mists of the national economy, teaching hospitals have been permitted to keep their endowments. The income may be used to finance research projects, for "amenities"—or embellishments to the hospital's personnel program, or for other purposes not directly related to hospital operations, the bill for which is conveniently paid by Whitehall. The arrangement is simple. There is no rate or formula under which hospitals are reimbursed on a per patient or per diem basis; the government just pays for everything. The cost records that the Ministry is asking for today are elementary; most hospital people think they will be required to submit much more detailed figures as time goes on.

More than many others, the huge teaching hospitals, with their vast wards and thousand-visits-a-day outpatient departments, are relieved to find that their financial problems are reduced to the inevitable budget bickering. Nearly all the voluntary hospitals were in financial difficulties before the health service act bailed them out, and the heavy added costs of the teaching programs had made the problem especially acute at most of the teaching centers. While one or two insist that voluntary support would have continued, most hospital people acknowledge that government aid was essential to continued operation of the hospital system. Listening to their talk about the mounting costs and diminishing contributions that made subsidy, if not nationalization, inevitable, in fact, gives an American visitor a chill sense of foreboding.

Many hospital administrators share the view of medical leaders who admit that something had to be done but beleive that the attempt to create an entire new system overnight was a dreadful mistake. Some think that a grant-in-aid program for hospitals similar to Britain's university grants committee, a professionally representative body that allocates government funds for higher education and research, would have been sufficient. Another view is that nationalization of hospitals probably had to come but should have preceded by some years the nationalization of medical practice, so that the adjustment to both these enormously complicated administrative mechanisms need not have been made all at once.

Now that it is done, however, even the bitterest opponents of socialized medicine realize that the deed can never be undone. With exceptions that are notably few under the circumstances, opposition activity is directed toward revision and modification of the program along fairly constructive lines, such as higher pay and freedom from administrative routines for doctors and more effective decentralization of the hospital management system, including election instead of appointment by the Minister of management committee and regional board members. Many critics of the plan feel that some modification of benefits will be necessary to hold down the excessively high costs of the service, but it is unlikely that the Ministry will permit the introduction of any "co-insurance" feature which would have patients making direct payments for service. In the concept to which both political parties in Great Britain are irrevocably committed, the costs of health service are a charge on society as a whole rather than the individual who receives the service; there will be no retreat from this principle short of general economic calamity—a possibility that has to be kept in mind.

What may readily come, however, is a separate health tax, which would accomplish the twofold purpose of increasing government revenue and giving the people a greater sense of responsibility about the health service, which has obviously been looked upon in the "free beer" spirit by a large segment of the population. Unfortunately, the question of a health tax and the issues raised by the other revisions and reforms that may be proposed will have to be resolved on political as well as medical and social grounds. This is the aspect of socialized medicine that everybody abhors but nobody can eradicate. This is the result that thoughtful people in the United States, in and out of the hospital and medical professions, fear most. Whether we can avoid it or not remains to be seen. It may be that the democratic method to which all of us are devoted carries in itself the seeds of eventual socialization. "It is conclusive against any theory of government," a British political economist of the nineteenth century once wrote, "that it assumes the numerical majority to do habitually what is never done nor expected to be done, save in very exceptional cases, by any other depositaries of power—namely, to direct their conduct by their real ultimate interest, in opposition to their immediate and apparent interest."

INTERESTS WILL COINCIDE

Obviously, there must be times when the real ultimate interest and the immediate, apparent interest of the people coincide. The British National Health Service may yet prove to be such an occasion, or it may prove that medicine will finally rise above politics of any kind. That is the view of a professor of medicine at London University who refuses to be disturbed by the present political turmoil. Looking into the fireplace in the governors' room at one of the great old hospitals there a few weeks ago, he recalled that the hospital had been serving the sick and needy of London for nearly one thousand years. "We survived the Black Death, the Wars of the Roses, the Plague, the Great Fire of London and two World Wars," he concluded. "Unquestionably, we shall also survive the National Health Service."

This is the third in a series of articles based on observations of the British National Health Service.—Ed.

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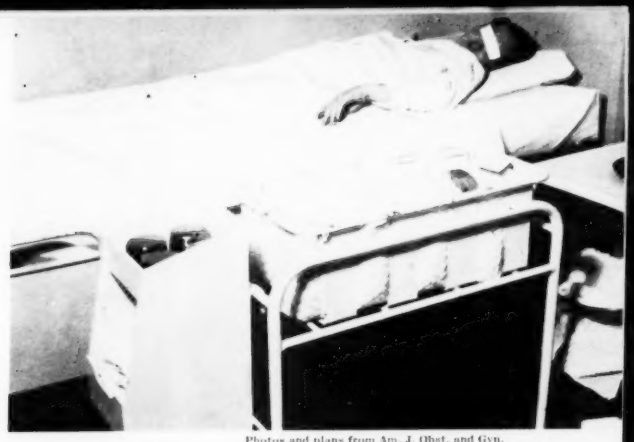


Photos and plans from Am. J. Obst. and Gyn.

Fig. 1. Baby, crib and equipment at the mother's bedside.

An administrator

an obstetrician and

a maternity supervisor

Evaluate the Rooming-In Plan

SUCH interest has arisen in hospital circles concerning the rooming-in of baby with the mother during hospital confinement that it appeared worthwhile to present to the readers of The MODERN HOSPITAL a review of this subject and a résumé of the considerable experience that the Jefferson Hospital has had with the project in the last two years. Also, it was felt that such a contribution might have particular significance if it correctly presented the combined views of the hospital administrator, the obstetrician, and the maternity supervisor.

To suggest that there is anything new in the policy of placing the newborn baby with its mother is to misstate the fact. Some 25 or 30 years ago it was common practice to have the baby housed in a crib at the mother's bedside. In many European hospitals it has always been the custom to place the baby in a crib by the mother's bed or suspended on the foot of the bed. Actually it has only been during the last generation that the baby has been removed from the mother's side and placed in a central nursery.

Just how or why this transition took place is difficult at the moment to state. Doubtless in the desire to improve hospital efficiency, and in the general enthusiasm over new methods of antisepsis and asepsis, it was conceived that a separate room, specially constructed, specially equipped, and specially staffed, would provide better and safer technic than could be furnished individually at the mother's bedside. Thus, in the recent return to the policy of placing the baby with its mother we have a demonstration of the recurring cycles and swinging pendulums of thought which are so frequently manifested in medicine as well as in other fields of human activity.

Actually, as we contemplate the fashion in which the physiologic function of reproduction has been developed in animal life, and particularly among mammals, and as we study the fashion in which nature has endeavored to set up natural safeguards for the birth and neonatal welfare of the offspring, one wonders how our obstetrical management of the normal case has come to depart so far from the normal path. The statement may properly be made that no physiologic function of the human body has been improved upon by man's efforts at modification or medication, to which the physiology of reproduction and the normal physiologic and psychic relations of mother and child are no exception.

Today, from 95 to 98 per cent of the deliveries in our larger cities are conducted in centralized institutions, most of which are hospitals constructed for the care of the generally ill and only modified in slight degree for the conduct of parturition. So rapid has been the growth of hospital practice in obstetrics and so limited the construction of new maternity facilities that it has been impossible to cope adequately with the demands for hospital maternity beds, and most institutions have been overcrowded and undermanned.

All of the older institutions and maternity divisions have been constructed on the principle of a centralized nursery, many of which house from 30 to 50 cribs. Infectious diseases, especially of the skin, gastro-intestinal, and respiratory tracts, have appeared with distressing frequency. In many of these epidemics of infectious diarrhea the mortality among the newborn has been high, and the public, as well as the medical profession, has been unfavorably impressed with the ability of the hospital to arrest and prevent these tragic occurrences.

Efforts to prevent these untoward complications have taken the direction of amplification of nursing facilities, the establishment of rigid rules for the care of the newborn, and the insistence by boards of health upon increased hours of nursing care per individual baby. These efforts, however, have not been totally successful for the reason that hospital construction, like all forms of building, has

lagged far behind the needs of the situation; and there has not been enough of trained nursing personnel during and since the war to fulfill the requirements of new and rigid regulations. Complicated procedures that have been set up for the central nursery have proved so exacting that breaks of technic inevitably occur, and any broken link may result in serious trouble.

The large central nursery has been incriminated. Obstetricians and pediatricians in various sections of the country have been considering doing away with it and establishing numerous small nurseries where the baby may be housed in intimate relationship with its mother. Barnett (3) reported an experience with the rooming-in arrangement for newborn babies in a small hospital. Jackson, Thoms and others (11) have established a rooming-in unit for four mothers and newborn infants where they are carefully studying the psychological relationship between mother and child. Montgomery, Steward and Shenk (12, 13) reported recently their experience with more than 1000 babies roomed at the bedside of the mother. Perhaps the first effort to adjust hospital architecture to this concept has been undertaken by McLendon and Parks (2) in the new hospital of the George Washington School of Medicine, Washington, D.C. From time to time under the urge of desperate circumstances it has even been suggested, by pediatricians at least, that a return be made to home delivery in order to protect the newborn infant from the ravages of epidemic infection.

In addition to these considerations, which have to do primarily with the health of the infant in central nurseries, other angles of the problem have attracted the attention of the pediatricians and psychiatrists. These other factors concern the disturbance of natural relationships between baby and mother in hospital practice and the subtle effect which such disturbance may have upon the ultimate mental health of the offspring. Moloney, Montgomery and Trainham (1) in Detroit have emphasized this point. They have founded the Cornelian Corner (9, 10), the function of which organization is to restore to the mother the companionship of her baby, to encourage breast feeding, and to surround the baby with affection and intimate care which appear to be of importance in early development (4).

Fig. 2. Ward carriage and equipment used for the care of the infant in morning rounds.

PROCEDURE AT JEFFERSON HOSPITAL

With these several considerations in mind the policy of rooming the normal full-term newborn baby with its mother was inaugurated in the obstetrical wards in Jefferson Medical College Hospital, Philadelphia, on July 12, 1947. Some six or eight months later rooming-in was made available to patients in the private and semiprivate rooms. In the case of the wards the arrangement was obligatory; in the case of the private and semiprivate rooms the service was optional. From July 12, 1947, to Feb. 12, 1949, 2430 newborn babies have been cared for in this fashion. Of these, 2141 are the offspring of ward patients, 181 are the babies of patients who are cared for in a low cost semiprivate ward, and the remainder, 108, are babies cared for in private and semiprivate rooms.

The baby is placed with its mother within from two to 12 hours after delivery (Figure 1). If the newborn has considerable mucus or if there is any question about its condition, it is retained in the nursery for several hours until circumstances warrant of its being placed by the mother's bedside. Occasionally, when delivery is at night the baby is not placed with the mother until the next morning. If the patient has had an operative procedure, such as cesarean section, the baby is usually not placed in the room until the end of the first or second day. Placement of the crib by the mother's bed is maintained both day and night unless one or the other is ill, or unless the baby is unusually restless. Such occasionally is the case on the first night or two, and on the private and semiprivate service the baby is occasionally moved back overnight into the nursery. Generally, after the second day there is very little restlessness or crying noted.

During the first 24 hours the nurses devote a great deal of time to the instruction of the new mother in the care of her offspring. They teach her the technic of breast nursing, how to cleanse the baby and change the diaper, what signs to watch for which might indicate trouble. During this time the mother does little more than learn about the care of the baby and observe its progress. After the first 24 hours, however, the mother is out of bed and is ordinarily able to care for herself and take almost complete charge of her baby.

Each morning the nurses assigned to nursery duty make rounds through the wards and private rooms with a ward carriage equipped for the weighing of the baby, changing of the cord dressing, recording of the temperature (Figure 2). Each mother is provided with a bath pack which contains the materials for the redressing of her baby, redressing of the crib, and a fresh supply of diapers, which she alone handles. She prepares her baby for weighing and examination as the ward carriage comes along and dresses the baby afterward. At these morning rounds the nurse collects the records concerning the baby's progress—weight gain, the number of feedings, the number of bowel movements—and inspects the baby carefully for local or systemic disturbance. Dry technic is employed in the care and only the areas in the folds of skin and around the anus are cleansed with sterile water and a cotton swab.

Subsequently the supervising nurse of the nursery makes rounds twice each eight hours. Other nurses are on hand on the floor or within ready call to help the mother with her baby at any time.

Mothers are encouraged to nurse their babies. The practice has been adopted of placing the baby at the breast in the delivery room as soon as the delivery is completed. This is in keeping with the fact that all newborn mammalians nurse immediately after delivery. The idea seems to meet with the hearty approval of the newborn for the wailing infant takes to the breast with avidity and looks very happily satisfied when it is finished. Subsequent nursing at the breast is on a so-called demand schedule. During

the first two or three days of life this schedule requires rather frequent feedings; sterile water or lactose water is given if the baby is still thirsty. After the milk comes in, the schedule of breast feeding settles down to every 2½ to 3½ hours, but no formal program is insisted upon. With the baby at the bedside it is possible to meet the individual needs of each newborn instead of insisting that the newborn meet the preconceived regime of the hospital (5, 6, 7, 8).

From the foregoing it may be properly assumed that both early ambulation and breast feeding are important factors in the success of the rooming-in project. It may also be stated that the rooming-in project is a stimulus and encouragement to lactation and an important factor in furthering the general and local involution of the maternal tissues. Under this regime the mother seems to recuperate more rapidly and is in much better state of health when she leaves the hospital on the fifth or sixth day of the puerperium than she was formerly after a week or 10 days of rest in bed.

The husband and the mother of the patient are permitted to see the baby at the regular visiting time. They are instructed to wear a gown, and if they wash their hands carefully they may hold the baby. No other visitors are permitted and these two are cautioned not to come to the hospital if they have any respiratory or gastro-intestinal disturbances. We have found that with the establishment of the rooming-in project excessive visitation to the patient is no longer a difficult problem. The remote relatives of the family and the friends seem to realize that this concept of mother-baby care does not permit of a roomful of visitors. The mother herself with the baby at her bedside becomes an excellent policeman in this respect. Actually the mother is so engrossed in the attention to her baby and so satisfied with its companionship that she desires no other visitors for the short duration of hospital stay.

BABY PROGRESS AND HEALTH

While our experience with the rooming-in project has been too short to permit of any final and categorical statement concerning its success or failure, nevertheless there are several observations of interest which have accumulated, and the impression is growing that rooming-in is a happy solution of many of the problems of

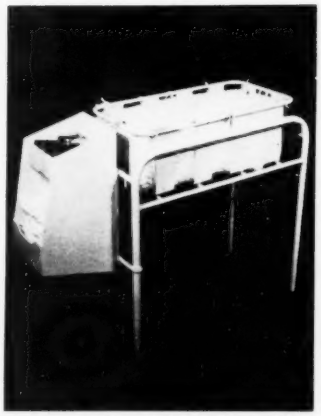


Fig. 3. The individual stand, crib and "crib wardrobe" which are used in rooming-in plan.

hospital care of the newborn infant.

In the first place, among these 2430 babies that have been housed with the mother during this time there has been no instance of epidemic diarrhea, impetigo or respiratory infection. While this record is better than that of any similar period of time in our institution it is realized that some individual infection may inevitably occur in the future and the slate cannot always be kept so clean. However, it is the impression of both the pediatric and obstetric services that if infection does occur it can be more promptly isolated and efficiently restricted than could be the case with the old central plan.

On the private service the infection can be kept to the room in which the baby is lodged. On the ward service it can be kept to the six-bed ward in which the baby is living. The six-bed ward can be quarantined and the other wards permitted to continue with their activities. The quarantine can be continued on the one ward until all babies are discharged and the ward is cleansed. Actually, in any one ward where infection arises there is considerably less chance of spread because of the fact that each baby is taken care of by its own mother and the babies are separated by a considerably greater physical distance than they are in a central nursery.

As an example of this epidemiological consideration there was one baby housed in a semiprivate room which developed a high fever and lethargy within 24 hours after delivery. Twenty-four hours later the mother developed the same symptoms. It was found upon careful inquiry that all the members of this patient's family, including all her other children, had been subjects of a peculiar virus-like infection during the previous two or three weeks. In this particular instance mother and baby were isolated in their room where the infection had started and no other babies or patients on the floor were involved. If this baby had been housed in a central nursery it is difficult to say how far infection might have spread before its significance was realized and before the baby could be removed. All of this, therefore, seems a much safer arrangement than the old plan where some 30 to 35 babies were housed together and all were exposed to the illnesses of one another.

None of these babies has had serious disturbances at the mother's bedside. Occasionally a baby chokes slightly after breast or bottle feeding, in which instance the mothers are instructed to turn the baby on its side, pat it gently on the back, and call upon the nurse for assistance. Facilities are available for prompt suction, and administration of oxygen if necessary. There have been two or three instances in which it has been necessary to do this, but in all cases the symptoms have been recognized early by the mother —possibly much earlier than they would have been recognized in an overcrowded central nursery. All the babies have recovered promptly.

In addition to these factors which have to do directly with the health of the baby, it has been noted that these babies at the bedside of the mother appear better contented, cry less, and gain more rapidly in weight than do the babies kept in the central nursery. When a baby cries the mother reaches out from the bed, inspects the baby to make sure that its diaper is dry, and feeds it if it is hungry. Usually this takes care of the situation and the crying subsides. Attending physicians, nurses and visitors, upon making rounds, have remarked how quiet are the wards and how little crying of babies by the mothers' bedside is noted. Certainly there is nothing which is comparable to the pandemonium which reigned in the central nursery an hour or more before the next scheduled fourth hour feeding time.

Our pediatricians say that these babies have never been as well taken care of as they are now under the mother's personal supervision. The mothers on the ward service take a special pride in the manner in which

they provide for their babies, and there is a great deal of competitive spirit among them as to who does the best job. From our point of view, therefore, the progress of these babies on rooming-in has been more than satisfactory.

BREAST NURSING

While it is true that most of our mothers on the ward service have nursed their babies at the breast in the past, yet the percentage in the past never reached the present figure of 89 per cent. We are informed also by the pediatric service that these mothers, as observed in the Well Baby Clinic, continue the breast feeding for as long as six or eight months after delivery. Approximately 20 to 25 per cent of the babies have regained their weight by the fifth day of discharge from the ward.

The present plan of management seems to have increased the efficiency and the interest in breast feeding in both ward and private patients, although the percentage of breast feeding among the private patients still lags far behind that of the ward patient. The presence of the baby at the bedside stimulates interest in breast feeding on the part of many mothers who might otherwise be reluctant. Also, the placing of the baby at the breast immediately after delivery gives the baby an excellent start at breast feeding and familiarizes the mother at an early time with the technic of nursing. Subsequent nursing on a demand schedule acts as a stimulus to breast secretion and many patients who have not been able to nurse their babies in previous pregnancies have found that the supply of milk has come in plentifully and has maintained itself well.

DISTRIBUTION OF NURSING CARE

The question as to whether additional nurses and a redistribution of nursing care are essential for rooming-in is important. Our observations on this score are of particular interest and possibly of considerable importance. We found that once we had the necessary and essential equipment for the individual treatment of the baby at the bedside, the change from nursery to bedside care was made without difficulty. Thus far we have made no change in the traditional assignment of nursing activities. Our student nurses still rotate between the labor and delivery room, premature and full-term nursery, the general day and night floor duty, and such special features of

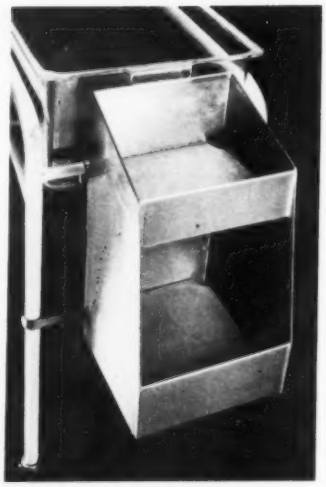


Fig. 4. New type of equipment consisting of plastic crib, stand, stainless metal crib wardrobe.

the departmental work as the formula room and the outpatient department.

The girls on nursery duty still have charge primarily of all babies—including those in the premature nursery, the few that are retained for varying periods of time in the central full-term nursery, and the babies at the mother's bedside. The group of nurses which is assigned to this duty makes ward rounds in the morning and checks the babies periodically during the day. However, it has also become the rule for the nurses on general duty on the floor, both night and day, to help the mother with the incidental problems that arise in connection with her baby at the bedside, and in this respect the lines of duty are not as strictly drawn as they were previously between nurses attending the baby and nurses attending the mother.

Whether it will be possible in the future to assign a nurse to the complete care of both mother and child is problematic. Our impression at the moment is that the old arrangement of duty is the more efficient. Of course, in the instance of private nurses taking care of private patients it is anticipated that the nurse will care for both mother and child during the time she is on duty.

The most significant observation that has come out of this nurse-patient adjustment is the fact that with approximately the same number of nurses and nursing hours, which under the old system was grossly deficient in terms of the "Regulations of the Department of Public Health for Nurseries," and deficient as regards our own desires in the matter, we have been able to set up in the rooming-in plan care of the baby which is adequate and reasonably satisfactory. Two circumstances have brought about this improvement in care. First, early ambulation has made it possible for the normal parturient to care for herself rather completely after the first 24 hours (and parenthetically we believe that the parturient is benefited by this activity); second, the rooming-in plan has made it possible for the normal parturient to take over the routine care of the normal full-term baby soon after its delivery. As a result of this policy it has been possible to concentrate nursing care upon those individuals in the obstetric division who need it most, that is, the ill mothers, the immediate newborn baby, and premature babies. For all of these the hours of nursing care have been built up to an *improved* if not a *completely* satisfactory level.

With the mothers participating in care the hours of observation and individual attention to the normal full-term baby have been increased practically to 24 hours out of the 24. The attention given to the baby by its own mother during these 24 hours is as meticulous as that which could be rendered by a graduate nurse assigned to each individual baby. It is questionable whether any number of graduate nurses assigned to the care of the full-term baby would do better than these mothers do themselves.

These statements as to nursing care should not be misinterpreted as an attack upon the high standards for nursing attention that have been set up by the Children's Bureau, but rather they are a partial answer to the problem of how the individual institution, which has never been able to do so in the past, can approach these standards. With the introduction of nursing helpers and the training of practical nurses it is quite probable that our conception of what constitutes adequate nursing care for the normal parturient and her full-term baby must undergo modification in the future. We do not feel, however, that there can be any safe modification in the care which is expended upon the premature infant.

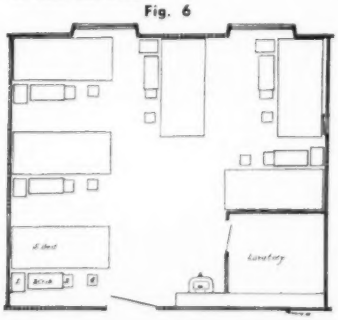
EQUIPMENT FOR ROOMING-IN

By process of trial and error we have found that certain minimal equipment

is essential for the care of the individual baby at the mother's bedside. For instance, when we first started, all the material for the cleansing of the mother's breasts, for the changing of the baby and refreshening of diapers was placed on a table in the center of each ward. Naturally it was soon discovered that this arrangement was totally inadequate because it permitted cross-infection and contamination, unequal distribution of materials, and waste. In order to ensure individualization we designed a small brace of shelves called a "crib wardrobe" which is attached to the end of the crib (Figure 3) and constructed to hold diapers, solutions and other necessities for the care of the baby and the mother's breasts. These crib wardrobes can be removed from the crib, readily washed, cleansed and repainted. The original model was prepared for us by our hospital carpenter. They are now being constructed of stainless metal by one of the Philadelphia instrument companies (Figure 4). It is important also to have individual cribs with casters which permit of readily moving the crib from one location to another. Recently, we have purchased for the private and semiprivate service individual stands, plastic cribs which permit of free visibility from all angles, and rubber foam mattresses (Figure 4). These with the crib wardrobes make very nice equipment, the total cost of which is something less than $50 per baby. At the moment it seems to us that this equipment is possibly more efficient than the rather cumbersome new type of cribs which have drawers beneath in an inaccessible position and an arrangement to swing the crib over the mother's bed. The difference in cost is also considerable.

At the moment we are using disposable paper diapers. The lucite plastic cribs have also eliminated the problem of washing and ironing materials to line the crib.

Fig. 6



Right: Fig. 5. General view of a six-bed ward. Below, left: Fig. 6. Plan of ward, showing (1) bedside table; (2) crib; (3) wardrobe; (4) chair; (5) bed; (6) wash basin. Below, right: Fig. 7. Plan of new four-bed semiprivate ward with small nursery. (1) bedside table; (2) bed; (3) locker; (4) bedside table; (5) wash basin; (6) crib; (7) crib wardrobe.

SPECIAL ARCHITECTURE

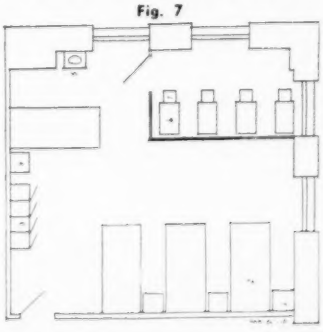
Thus far no special architectural adjustments have proved necessary. Fortunately, our obstetrical wards, which were built some 20 years ago with no thought of rooming the baby with the mother, lent themselves fairly well to this undertaking. The ward service consists of six rooms, each containing six beds (Figures 5 and 6). Each of the wards has its own bathroom and each has its own wash basin. The rooms are ordinarily well heated and the windows are equipped with ventilators. In addition to the six wards of obstetrical patients there are a labor room of four beds, a nursery for full-term babies, a premature nursery, an isolation nursery, a formula room, central office, sterilizing room, and service rooms. All of these occupy one floor of the Samuel Gustine Thompson Annex, the wards and nurseries being arranged in a rectangular fashion about a central office. There is free visibility from the corridors into the rooms and from one ward to another. The nurses, residents, interns and student clerks circulate rather constantly through the various parts of this obstetric floor, so that mothers and babies are under frequent observation during the day and not infrequent observation at night.

All of the private and semiprivate rooms are also provided with bathroom facilities and wash basin. In the private rooms there is ample space for the placing of the baby's crib beside the mother's bed. In the rooms which are at present being used for semiprivate patients, space for two maternal beds, two cribs, and other furniture is not too abundant.

As a matter of fact, within a few months a new wing for private and semiprivate patients will be completed at the Jefferson Hospital in which the special needs of the rooming-in project are to be considered, although no great deviation from the usual hospital architecture is contemplated. Each of these rooms is to be furnished with a wash basin equipped with gooseneck fountain and elbow controls. The furnishings of the rooms are to be such that space will be available for readily placing the baby's crib at the mother's bedside; and in the instance of two of the larger rooms, which are to contain four semiprivate maternal beds, a small nursery is being constructed within the room (Figure 7).

We have carefully studied various plans for peripheral small nurseries. We recognize that this arrangement has the advantage of cutting down the census of babies in any one nursery and thereby reducing the risk of infection of the newborn. However, every peripheral nursery requires its own equipment and a group of nurses to man it. While in the daytime babies may be left in such a peripheral nursery under the observation of the mothers, yet at night there certainly must be someone in and out of the nursery constantly to watch these babies. This plan, therefore, requires expensive hospital architecture and requires what for most institutions is an almost im-

Fig. 7



possible increase in the number of graduate nurses in attendance. Nor does it provide true rooming-in or bedside care of the baby.

In the plans which have been formulated at Jefferson provision has been made for a suite of premature nurseries and a suite of three central nurseries, each of which will accommodate from eight to 12 babies. It is hoped that in due course only one of these full-term nurseries will be employed, and that for reception of babies before they are placed with the mother. If such proves to be the case the other two full-term nurseries are so arranged that they can be converted into patient rooms.

Criticism has been leveled at the fact that occasionally a baby is sent back overnight to the central nursery. It has been pointed out that such an arrangement permits of contamination of the central nursery by this baby which has been out in the mother's room, exposed to contact with the mother and with visitors.

While theoretically this is a valid criticism, practically it has given rise to no apparent trouble. Visitation is limited to the husband and mother of the patient, and these are urged not to visit the patient if they have any respiratory or gastro-intestinal infection. Actually the contacts of the baby in the mother's room are limited. We are of the impression that this potential danger is greatly counterbalanced by the reduction of census in the central nursery, by the individual care that is given to each baby by its mother, and by the relatively complete isolation of the baby with its mother.

Ultimately, of course, all babies must go home and be exposed to home environment and to contact with parents and other members of the family. Also there is the question of how far hospitals are going with intricacies of obstetric floor architecture and with provision of graduate nursing care without making the cost of childbearing prohibitive to our young generation. It would appear that some compromise between the practically efficient and the theoretically perfect will have to be made if obstetrics costs are to be kept within reasonable limits.

The ideal architectural arrangement for the rooming-in program has not been achieved. Doubtless a great deal will be learned within the next few years from those institutions which are already experimenting with these ideas. To the authors it would seem wise to keep plans on a relatively simple basis and continue to preserve space for small nurseries. Simplicity of planning for rooming-in should appear to be just as effective as some of the more complicated arrangements which have been undertaken.

REACTION OF PATIENTS

The final question that arises is whether the mothers themselves enjoy rooming-in and appreciate its presumed advantages.

On the ward service rooming-in has been made mandatory and all patients who register for ward care understand that they are to have their babies with them and are to participate in the babies' care. Under these circumstances the patients accept the regime which is established by the hospital, and take to the project with something more of interest and enthusiasm than a mere compliance. These ward patients appear to enjoy the companionship of their babies, manifest a great deal of pleasure and pride in caring for their babies, and are jealous of the interest and safety of their babies. Practically all of them say that they like the plan and enjoy having their babies with them. They all feel that they are in a better position to take care of the baby upon discharge and understand the interests and behavior of the baby better than with any previous arrangement.

Among the private and semiprivate patients young first mothers are often the quickest to realize the value of the new project and are sometimes the most enthusiastic, although not a few have apparently been cautioned by their own families that they should not undertake rooming-in because it will interfere with their rest and the recovery of their strength. Not a few of the physicians have this same point of view, and therefore many a young mother who seems rather eager to care for her baby is afraid to undertake it. This, of course, is not at all surprising considering the fact that for the past 25 or 30 years the obstetrical profession has been indoctrinating its patients in the concept of central nursery care.

If eventually it can be demonstrated that rooming-in is a better plan than the old central nursery idea, then we shall have to reeducate our obstetrical patients into this revised concept of obstetric care.

To the patient who has strong maternal instinct and abiding affection for her offspring the rooming-in project provides a great deal of satisfaction. Not a few multipara take kindly to the plan and state that they wish all of their babies had been handled in this fashion.

If in the course of time it can be demonstrated that the rooming-in project is rational, is safer, and presents an improved relationship with mother and child, then the obstetrician may be able to say authoritatively that this is the way the baby should be handled. Under such circumstances the vast majority of patients will doubtless accept the idea and cooperate in the same complete fashion as the ward patients do now. Up to the present time we have not felt that we could speak with such authority or that we had the right to dictate to the individual obstetrician how he should manage his private practice in this field. It has not proved difficult on the private floors to take care of the portion of the babies in the central nurseries and a portion of babies in the private and semiprivate rooms so that rooming-in and central nursery care have gone hand in hand, and probably will continue to do so for some time.

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Group Clinic Starts a New Chapter in the History of Rural Medical Care

Exterior of the Toccoa Clinic, Toccoa, Ga.

WILLIAM HARMAR GOOD JR., M.D.
The Toccoa Clinic, Toccoa, Ga.

CONSIDERABLE interest is being shown in the problem of providing good medical care in small towns and rural communities. Most articles on this subject are written by men who are themselves working in medical colleges and metropolitan centers. Their information and their suggestions are drawn principally from health and medical care statistics and observation from a distance. This has a distinct advantage in that they are able to see the broad panorama of the woods unobstructed by the trees, and many valuable approaches to the problem have been suggested. The present discussion is written by one of a group of men who decided to attain specialty training, and then use themselves as guinea pigs for an on-the-ground experiment in rural medical care. Their approach and its practical application over the course of several years are presented.

DEFINE GROUP PRACTICE

It was the thought of the founders of the Toccoa Clinic, Toccoa, Ga., that it would be possible to assemble a small group of well trained specialists having common interests and similar points of view. These men, leaning on each other for moral support, could settle in a small town and practice as a group. For purposes of clarity, we defined group practice as follows: Two or more men, usually trained in different branches of medicine (although not necessarily so) who have pooled their personal skill and medical knowledge, and who have access to pooled facilities and ancillary personnel. We felt that it would be hard to deny that such men could give their patients a type of medical service that would be impossible for any one of them to render individually. This service can be given at greatly reduced cost to the individual patient. The possible ways such a group can arrange its finances are many and varied, and the only rule is that the arrangement be flexible enough and unselfish enough to be reasonably satisfying to all. The members of a group must be men who feel that some sacrifice in the size of personal income is worth the advantage of sharing responsibility, of increasing leisure hours, and of giving more nearly complete care.

Once such a group is formed and settled in a small town that is the center of a trading area, it can become the rallying point for doctors practicing individually in the surrounding territory. It can provide them with on the spot consultation help. It can offer them x-ray and laboratory facilities. It can integrate their efforts without interfering with their independence (and that point is important, too). When such a group is at hand in a community, it provides the trained personnel that makes feasible the building of a good hospital. When this is done, the establishment of a small medical center is an accomplished fact. Once we have advanced to this stage, the field is open for a train of developments that can have only one end result—a region no longer lacking in good medical care.

The group must constantly keep in mind its responsibility to stimulate and educate the individual practitioner. Many men urge the medical educational facilities of the large city as a reason for staying there. It is true that our group will not expect to have a great volume of unusual and instructive cases, yet the variety and the problems that arise will be surprising. There will be plenty of material for discussion and instruction if it is properly handled. The field of medical motion pictures is a rich one already and is improving in quality constantly. It is not too hard to attract eminent teachers to occasional meetings in places where they know good work is being attempted conscientiously. Interesting meetings and clinical conferences, therefore, are feasible. The practitioner can be made to feel that he has a place in the organization. If he feels a genuine welcome in the hospital or clinic, he will learn to visit often, to depend more and more on its help, and he can scarcely avoid growing in knowledge and ability. This works two ways because it enhances the prestige of the group and swells the volume of referred work. It is a circle, but, happily, it is not a vicious one.

NEED TRAINING FACILITIES

No one who has had teaching experience would say that a specialist could receive his entire training in a small hospital or clinic, but we still do not have enough training facilities to meet the demand. When there is a certified man in a group and a good, even if small, hospital has been established, there is no reason to suppose that a considerable part of the clinical training of one or two men could not be accomplished there in collaboration with a distant medical school.

It is even more possible to provide for several interns to serve part or all of their internship at the local hospital. Men who come to such a place to train soon become interested in the problems of small town and rural practice. They also are acquainted with its advantages. Many are attracted to

neighboring towns. They are willing to settle under the shadow of the institution where they were trained. There are other homelier but none the less compelling reasons why some stay near by. They make friends or they fall in love with local girls, for instance. Over a period of years this trend can result in a constant stream of young doctors into the territory served by the group.

Young men growing up in a town where a successful group is practicing are more likely to seek a medical career, and some of them will come home to practice.

COULD TRAIN NURSES, TOO

At this point we might diverge to an allied subject. There is a serious shortage of nurses. The raising of educational requirements and the concentration of training in a few large institutions are partly to blame. Also, the nurses graduated under this scheme demand, and justly so, a wage that most people cannot afford. The training of nurses on different levels has been advocated by some. We shall not discuss the merits of such a plan. But we do know that there is a reservoir of young women in rural areas that will not go to college or travel to the city for three years of training, but that would be attracted to a small training school in their community hospital. If the proper standards were maintained, they could be trained in such a place to give very good nursing care to sick people. They might not make teachers and they might not even be material for supervisory or specialized work but they could give good general care, and they could answer the cry of "how can we attract nurses to this community hospital in a small town?" They certainly would be better than the system of using haphazardly trained (really untrained) aides that we have observed in some rural hospitals.

Going back to our small group, we find that it has problems and limitations. It is important that the members be integrated with the metropolitan teaching centers. There is where the surgeon, the radiologist, and the pathologist in the small group must turn for help and stimulation. There will always be cases that are so unusual or complicated they should be treated in a university hospital, or one of similar size. Research can be carried on by a small group only to a limited extent without wasting resources. It would be folly for a small town group to attempt to provide the more complicated care. For instance, we can not imagine a neurosurgeon practicing in rural Georgia. The medical school stands as the hub of a wheel within which there may be many small wheels.

The Toccoa Clinic is regarded by the doctors working there as an experiment in medical practice to test the validity of the propositions set forth. It is situated in a town of about 8500, the seat of a county of 16,000 population. Toccoa is a trading center for a population of at least 30,000 in surrounding counties. The region is predominantly rural, dotted with farms and small towns. In Toccoa itself are several sizable industries, including a thread mill, an iron foundry and a factory manufacturing heavy road building equipment. These three plants employ close to 3000 people, and more than 90 per cent of the employes are members of hospitalization insurance plans. In addition, there are a number of small industries, including a cotton mill and several furniture factories.

It is evident that the town has a diversified and fairly stable pay roll. It is 95 miles from Atlanta, the nearest metropolitan center, and the nearest medical school is Emory University in that city. There are two surgeons, both members of the American College of Surgeons; one of us is certified by the American Board of Surgery. One of us is interested in general surgery, and the other in fractures and other trauma, and the problems of industry. We have found that industry has many interesting facets and can be an important foundation for group practice. The third man is trained in internal medicine and radiology. With only a little outside help (a large starting capital is not needed in our experience), we have been able to establish a clinic that has a diagnostic x-ray unit which even a city hospital could be glad to own. We can give all the usual surgical and medical care that does not require overnight hospitalization. We can do simple laboratory work now and are hoping to provide a more nearly complete laboratory soon. At the same time we are making a reasonable living. What is more we are having a whale of a lot of fun doing it. Our pooled resources enable us to have an expert medical secretary, several capable office assistants and a registered nurse. Finally, we have personal freedom from the constant demands of practice. The freedom to live a more normal life makes group practice worthwhile without considering any other advantages.

There are many problems, and since ours are probably not unique it may be well to set them down. Most of the doctors who have been settled in the area a long time are inclined to look upon the clinic with suspicion, but more and more they will learn to use the facilities of the clinic and the skills of the specialists. There is the problem as to whether we should do only specialty work or do general work, too, and allow men to join the group for that purpose. It might be well to withdraw entirely from competition with the general practitioner in his field. However, specialization is a new idea in North Georgia. People do not understand why you are able to take out their appendix, but unwilling to treat their mother's heart dropsy, and resent refusal. One has to be diplomatic and not too rigid in handling these situations.

DON'T WISH TO SPECIALIZE

The local doctors themselves have not been trained to specialization; they wish to be jacks-of-all-trades. Young men with only a brief training set up as "physician and surgeon." The public does not know how to distinguish the trained men. A clinic can succeed only when men learn to refer work, and the general practitioner-surgeon passes into deserved oblivion.

In Toccoa we found a small hospital already established to which we could take our major surgery. However, the clinic is faced with the problem of bringing the standard of this institution to a more desirable level and making it grow to a point—as to both size and excellence—where it can handle some of the broader responsibilities mentioned earlier in this article. Unfortunately, every step in this direction must be contested with those who would prefer to maintain the status quo.

There is a challenge in these small town and rural communities. In the next 25 years the men who are willing to accept this challenge and spread good care out from the cities are going to make medical history and write a bright chapter in the already proud annals of American medicine under free enterprise. It is hoped that some readers will interest themselves in this problem and join the number who will be writing this chapter.

DANGEROUS CURVES on the road to solvency

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HOSPITAL administrators are accustomed to watching for danger signals at all points in their institutions. It may be somewhat of a relief, therefore, to consider danger signals that may arise from the credit angle instead of those that have to do with the patients' welfare. Credit implies a reliance upon truth, a faith, trust or belief in individuals. Probably the greatest danger signal which may arise in a hospital is evidence of a loss of faith or confidence which people place in the hospital. Certainly, we must take all measures to guard against this.

Originally, hospitals required no credit structure. If we think of them as charitable institutions with a basically religious motive, there was little place in their daily functions of years gone by for a credit manager or for any thought pertaining to collections or financial management. Today, with the development in hospitals of numerous ramifications and relationships of varied sorts, it is extremely difficult to conceive of any sizable hospital's operating satisfactorily without some sort of business office and due attention to its credit arrangements.

MUST BE BUSINESS-LIKE

It has, indeed, been extremely hard for many to reconcile the original conception of hospitals as charitable organizations with more recent ideas of the need for operating them on a business-like basis. Without doubt, however, the time has long since passed when hospitals, like any other industry, can fail to take account not only of the reasons for their existence but of the means to maintain that existence. This, I believe, can and must be done without in any sense losing the original conception of the purpose of the hospital as a service institution, and the primary consideration that its business is to deal with sick individuals and those individuals' comfort and welfare. As in hotels so in hospitals, the customer or patient is always right. We are his haven, his protector, his guardian for a limited time, and this not always of his own choosing.

It will be the endeavor of this paper merely to point out a few danger signals pertaining to the hospital's financial dealings which are currently becoming more and more significant.

The first danger signal I would suggest, which is apparent to such hospitals as have endowments of any size, is the noticeable fact that the returns from their invested funds are no longer sufficient to meet the deficits which their hospitals incur. This has necessitated in numerous instances within the last two years the dipping into capital funds to meet operating expenses, a procedure which hospital boards are naturally extremely loath to do. How this danger can be met has been a source of concern to many a hospital trustee within the past few months, the answer seeming to be the inevitable one current in all business today of finding additional sources of revenue from the community which the institution serves. A hospital cannot, like many businesses, increase its revenue by increasing its productivity. It is not that simple, except perhaps in the maternity department.

A second danger, similarly apparent to all hospitals, is the falling off of voluntary contributions. I do not have facts at hand to show that there has been an over-all reduction in the amount of voluntary contributions made to hospitals. Doubtless there has not, but in many instances hospitals have noticed a decrease in both the number and amounts of their donations from philanthropic sources. It is true that many an institution has made corresponding gains from more active publicity effort, so perhaps the total picture shows the hospitals to be better off now than they were three or four years ago. Nevertheless, it must be admitted that sources of large contributions have in many instances been reduced and it seems to behoove hospitals to continue their efforts to make it easy for individuals to contribute and to go much farther in suggesting ways and times when such contributions will be most effective. If every hospital administrator does not have at hand a list of the institution's needs attractively ready for presentation, he had better prepare one.

Another danger signal of which the credit department should be keenly aware occurs when it is noted that rates charged per day or per service are less than cost. This gives rise to the entire question as to whether hospital charges to individuals or to governmental bodies should be based solely on cost, or whether there is in some instances justification for an alteration from the basic policy in making charges. I know of some hospitals that are still trying to operate on an even keel where their charges for even the highest priced private rooms are not equal to their average per diem cost.

ESTABLISH ACTUAL COSTS

It has been mentioned many times recently, and I should like to emphasize again, that governmental bodies, whether federal, county or local, have become so accustomed to paying an arbitrary fixed rate for hospital services that it is extremely difficult for them to conceive of paying on any other basis whether it be actual cost or even a fraction of cost. Much headway has been made over the country in the last year toward the correction of this difficulty, and instances can be quoted in which hospitals, when making a sincere effort to cooperate with such governmental units and, in some instances, including the use of pressure, have succeeded in obtaining a payment based on their actual cost. It goes without saying that hospitals must be in a position to quote and substantiate true cost figures.

An additional danger signal which is most apparent is when our accounts receivable rise above a certain level, above a certain percentage of the total billings. What this percentage should be is a matter of some debate and may well vary. What it actually is has been shown recently to vary anywhere from 1 per cent to 20 per cent. One can only say that it is certainly sound judg-

Presented at the Arizona Hospital Association meeting, February 1949.

ment to endeavor to operate a hospital with an active accounts receivable item which is not more than 10 per cent, while if it falls within 5 per cent it might be termed reasonably satisfactory.

In this connection, I should like to digress a minute to point out that many hospitals either do not care to or do not take the trouble to distinguish between what may be called bad debts and what is true charity. Many a hospital has been unable to state in specific terms what its charity load was, and invariably the answers, when this question was asked, indicated that the hospital considered its charity load to include not only accounts of those who were known to be nonpay patients but also a large percentage of the accounts of those patients who had been unable to meet their obligations and who, in a stricter accounting sense, must be considered bad credit risks or bad debts. Perhaps it makes little difference, after all, since such accounts will not be paid and the hospital must render the service. Nevertheless, I believe that it would be much to the advantage of an institution to be able to say in no uncertain terms: "We do so many dollars' worth of free service each year and we have also so many dollars' worth of uncollectible accounts, or bad debts, which we consider a service rendered to the community and have had to charge off."

WHEN ACCOUNTS PAYABLE INCREASE

An additional danger signal, which is perhaps a little aside from the patient credit angle yet is one I am sure most hospital administrators recognize, occurs when our accounts payable tend gradually to increase from month to month. Here we all have to combat the tendency to put off until next month the payment of certain bills when the vendor is not pressing, offers no discount, and is a long established contact. This is a danger signal which good administrators should not allow to exist. Bills must be met and paid in spite of the leniency of many of our hospital supply industries. It is only good business and good public relations to meet our obligations to these firms just as we meet those of any other creditor.

Another danger signal, which is a corollary to the last one, is in the use of discounts of various sorts. This may apply either to our accounts payable or, more particularly, to the many systems which have been applied to accounts receivable. In some hospitals specific figures have been applied to all accounts. While this seems to have worked satisfactorily in some instances, the basic philosophy upon which such discounts are granted seems not in keeping with the proper concept of hospital finance and, in general, may be said not to be good policy. The mere fact that the use of such discounts arises is to us an indication or a danger signal that financial considerations are not what they should be.

Another danger signal is found in the tendency to turn over to collection agencies accounts which appear to be difficult to collect. Some hospitals apparently have never had to resort to this measure. Most modern institutions of any size do, and although the manner in which such agencies are used varies widely, and the time element involved both before accounts are referred to collection agencies and before such accounts are completely closed shows an extreme variation of anywhere from two to 24 months, we are of the opinion that many more hospital boards might well consider more carefully their methods of handling such delinquent accounts through proper collection channels than is at present the custom.

One of the most obvious danger signals, perhaps a little less so now than it was a few months ago, yet one of the most important, from a hospital administrator's standpoint, is the reason given in many instances why the hospital has not arranged a more nearly complete credit and collection procedure, *i.e.* because the hospital is short of personnel. Is it not rather shortsightedness on the part of the hospital administration to refuse to recognize, in times of increasing need for attention to financial accounts, the necessity for supplying adequate employes both in numbers and in training to handle what must become to them an all-important item of their existence? How frequently are matters of credit arrangement, payment and follow-up left to a poorly trained subordinate clerk, with consequent errors, which are difficult to correct, and irreparable loss of good will?

A further danger signal is the increasing insistence by hospitals upon down payments. I do not in any way desire to leave the impression that down payments for hospital bills are undesirable. I adhere to the general belief, however, that the fact and the amount of the down payment are far less important than is an adequately secured agreement to pay, and I know of more than one hospital which, in its desire to increase its immediate income, has insisted too firmly that down payments be made before admission of a patient, to the great detriment of its public relations. This is a matter, after all, of general policy for each institution to determine, but it must be emphasized that it mirrors the intent of those who run the institution, the trustees, and can be handled rigidly without exception or much less so and tempered by kindness and still be most effective.

INSURANCE PAYMENTS

Perhaps one should not list as a danger signal the problems which have arisen in connection with Blue Cross and other insurance payments. Nevertheless, perhaps the increased interest in Blue Cross accounts and in similar group payment schemes reflects a sensitiveness to the difficulties in meeting average hospital payments. Such plans are valuable both to the average citizen and to the hospital. They do, however, give rise to problems of collecting balances on accounts after payment by the insurance companies. This has led to much confusion in the minds of patients and to no little difficulty in hospital business offices where special procedures have to be inaugurated to handle such balances.

The use of flat rates either for entire hospital billings or for certain types of cases is not new to hospital heads and has received considerable emphasis and experimental effort in the past few years. This in itself is another danger signal, a device, and an indication that all may not be well in the hospital's financial structure. Opinion at present seems to discount the value of the flat rate as a procedure that is generally applicable to most institutions.

In closing I believe it a fair statement that, in general, the credit experience of hospitals the past few months has altered but little from that of a year ago. If anything it has become a more acute problem. If in these uncertain times we can forecast anything with any assurance, it would seem that matters of hospital finance and credit arrangement are going to become of increasing concern to administrators and boards of trustees. It behooves every institution to investigate from time to time the details of its business operations with a view toward improving them.

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THREE SMALL HOSPITALS

GEORGE BLUMENAUER
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THIS article was prepared with the sincere hope of developing several small hospital layouts so designed that it might not occur that ere the builder could move out and the operating personnel move in the facility was already obsolete in some of its phases. A good planner, indeed, is he who can plan the Hospital of Today which will fulfill *today's* needs.

The accompanying layouts were studied from the point of view of conserving space without sacrifice of essential service; of conserving construction and equipment costs and holding stepwasting and labor duplication to a minimum when performing routine hospital tasks, and thus of conserving the time of personnel and staff members. Certainly, time is money in today's hospital.

Problems to be anticipated in different parts of the country conjunctive with climate and local customs can best be solved as the local facts are obtained and evaluated.

In some parts of the country race segregation problems are encountered. The segregation factor is variable. Throughout the northern part of the country it may be met only occasionally. In border states, such as parts of northern Oklahoma and northwest Texas, the segregation median will run as low as zero to 5 per cent. Further south and in Arkansas, the ratio would be much higher; Alabama, Mississippi and other states have areas where the Negro population is a majority. Occasionally it would be expedient to plan a hospital wholly for Negroes.

Separate reception rooms, toilets and provisions in nursing sections for segregation can be oriented in the plan only when the situation that exists in the community to be served by the hospital is evaluated.

It is assumed that architectural design of hospitals—as with all good art—should be of a nature to help carry on the best of the community's culture. It should be something which the people instinctively will like. The new hospital should not have the look of an incongruous stranger in the community.

Like a lovely lady's well chosen garments, the design of the hospital, among other carefully considered virtues, should be an endeavor to contribute constructively to the esthetic aspect of its environment.

15 BED HOSPITAL

This small hospital plan was developed at the request of a busy surgeon in one of the large cities of the Southwest, who hoped to build an efficient, one-doctor hospital which would have all essential facilities and nothing superfluous. Cost must be kept down.

The doctor also expressed the viewpoint that he might want to call in fellow practitioners occasionally, or a fellow practitioner might wish to have a patient or two in the hospital. Mechanical equipment must be held to a minimum. Rooms had to be small, efficient units.

The floor areas are as follows:

	Area Sq. Ft.
Basement	2,091
First Floor	4,669
Total Area	6,760
Total Floor Area Per Bed	450

Some critics studying the plan may envision elaborations or enlargements. The executive department and doctor's space might be larger; a direction for extension is suggested. There is space for lavatories in patients' rooms, should they be required. The doctor said, "Omit lavatories in patients' rooms. It is a small place and lavatories are close at hand anyhow."

It was intended that custom laundry service would be preferable to operating a hospital laundry. In case the hospital deemed it expedient to operate a laundry, the space in the basement may be equipped with a washer, a drier and an ironer; it is an economical layout, simple as a home laundry.

A small second floor might be added to include a recreation department for nurses, a medical library and research room, and possibly a sleeping room or two for emergencies.

21 TO 27 BED HOSPITAL

The 21 to 27 bed design was developed early in 1946 at the request of a small city in the north central section of Oklahoma which was in need of an economical small hospital of about 25 beds capacity.

The floor areas are as follows:

	Area Sq. Ft.
Basement	2,827
First Floor	9,987
Second Floor	1,721
Total Area	14,535
Total Floor Area Per Bed, 21 Beds	692
Total Floor Area Per Bed, 27 Beds	539

Normally, with five private rooms for general nursing, the capacity is 21 beds. Each private room is sized to accommodate two beds which, particularly when the hospital is crowded, would increase capacity to 27 patients.

Work areas for personnel are compact and placed with convenient relation to the intended purpose, thus leading toward a minimum of wasted effort and steps on the part of personnel and staff when doing routine tasks. Closet combinations in the toilet space in patients' rooms are intended to have bedpan washing attachments.

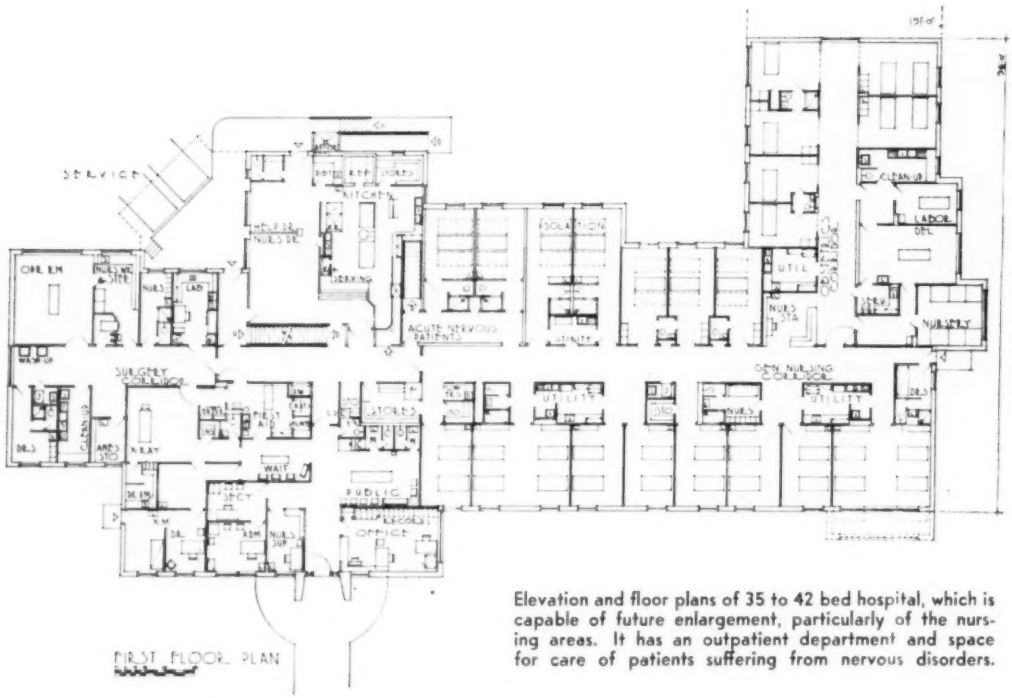
35 TO 42 BED HOSPITAL

This plan is an offspring of one of the six prizewinning designs in the "Competition in Plans for a Small Hospital," sponsored by The Modern Hospital Publishing Company, Inc., and judged in Chicago, December 1944. It was prepared and submitted by me in collaboration with Paul Fesler, administrator, University of Oklahoma Hospitals, Oklahoma City.

The design submitted in the competition was for a 40 bed general hospital which might be expanded to 60 beds, without necessarily increasing the size of kitchen, mechanical department, storage areas, administrative department, and like service areas. It was an original conception, of necessity somewhat hurriedly done and I was never too pleased with it, albeit it

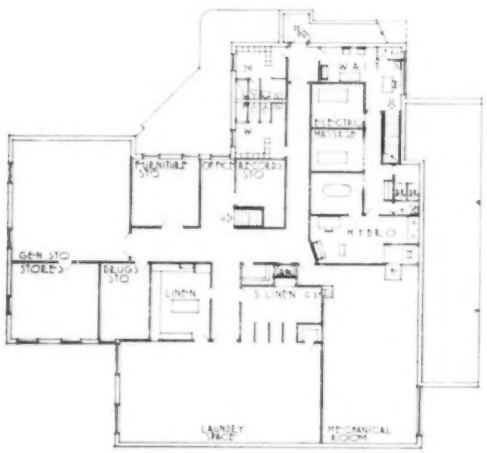
(*Continued on Page* 60.)

FRONT ELEVATION



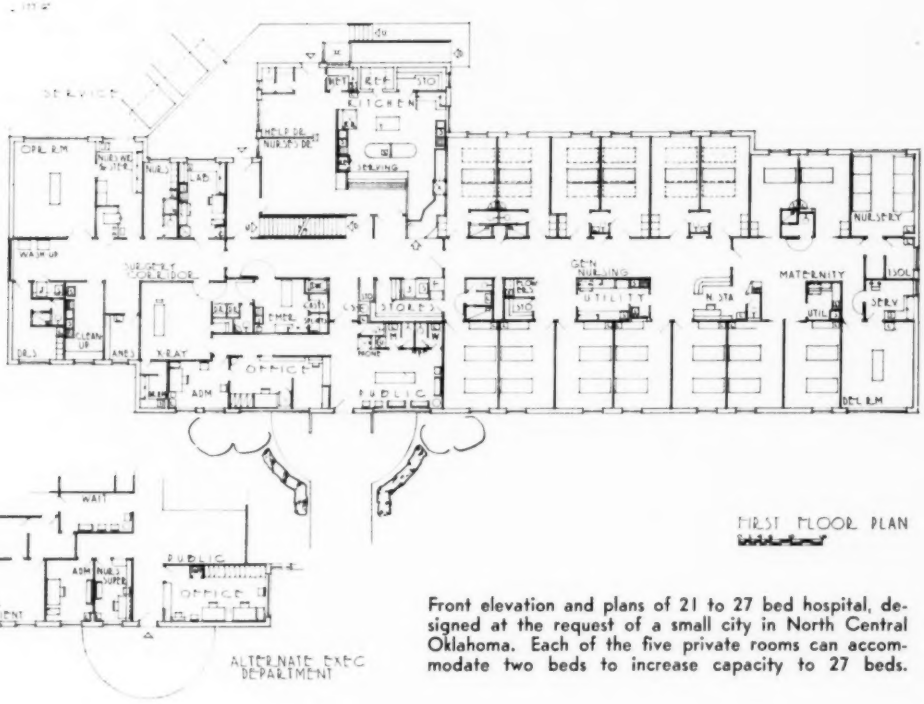
FIRST FLOOR PLAN

Elevation and floor plans of 35 to 42 bed hospital, which is capable of future enlargement, particularly of the nursing areas. It has an outpatient department and space for care of patients suffering from nervous disorders.



BASEMENT PLAN

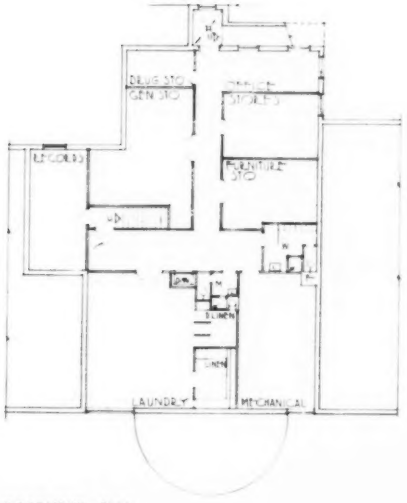
SECOND FLOOR PLAN



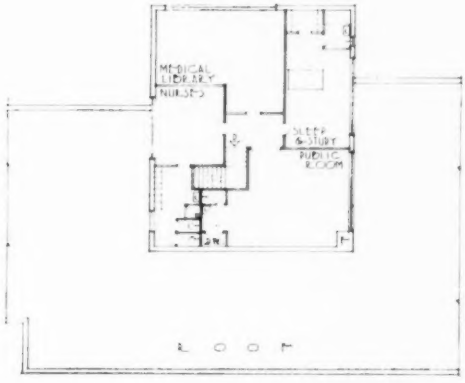
FIRST FLOOR PLAN

ALTERNATE EXEC DEPARTMENT

Front elevation and plans of 21 to 27 bed hospital, designed at the request of a small city in North Central Oklahoma. Each of the five private rooms can accommodate two beds to increase capacity to 27 beds.

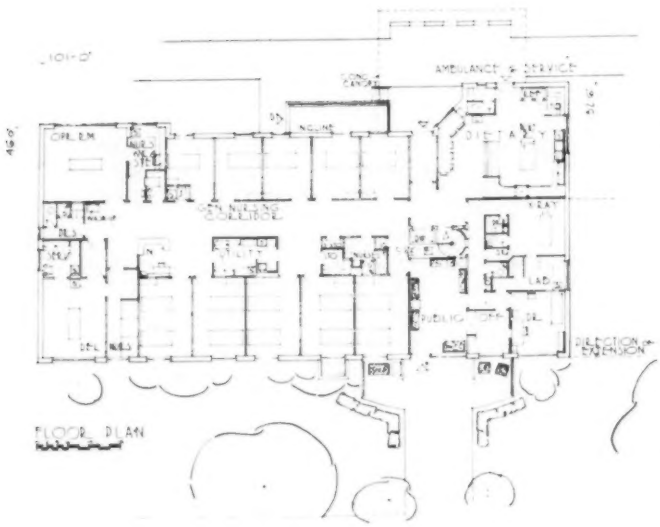


BASEMENT PLAN

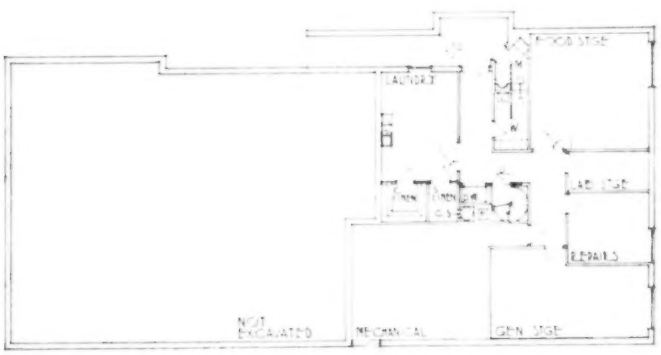


SECOND FLOOR PLAN

FRONT ELEVATION



FLOOR PLAN



BASEMENT PLAN

Elevation and plans of a 15 bed hospital, built for a surgeon in the Southwest. Rooms had to be small, efficient units. A second floor can be added.

stood as one of the six prizewinning designs.

In later studies toward perfecting that design the design for a 35 to 42 bed general hospital took shape in an effort to develop a compact, economical to operate hospital under 40 beds capacity; and one with some possibility for future enlargement or extension, particularly of the nursing areas.

The floor areas are as follows:

	Area Sq. Ft.
Basement	6,078
First Floor	12,661
Second Floor	1,920
Total Area	20,659
Total Area Per Bed for 35 Beds	590
Total Area Per Bed for 42 Beds	482

This plan is oriented on a conception parallel with the 21 to 27 bed plan described. It has an outpatient department and a department for hospitalizing and treating individuals in the community suffering from acute nervous disorders.[1]

GENERAL:

In each of the designs the food service is intended to be brought from kitchen to nursing sections by food cart. Since the kitchen is reasonably convenient to nursing sections, floor service kitchens seem unnecessary.

Questions of heating and air conditioning comprise extremely variable factors. Solutions to these problems can best be based on appraisal of the local climatic conditions and also on the availability of funds.

Where beds for isolation are a requirement it would be a simple matter to plan for them, with access from the general nursing corridor.

It is assumed that a sizable dumbwaiter will meet normal requirements in transporting routine items from floor to floor to supplement stairways or the outside ramp from ground to basement. In the 35 to 42 bed layout, where an electric or hydraulic elevator is considered essential, space would have to be found for it by rearranging an area which is already scheduled for intensive use.

If a recovery room (or rooms) is deemed necessary it can be located at the left end of the plan, with access from the surgery corridor.

[1]Blumenauer, George: The Planner's Problem Child. Southern Hosps. 17:28 (February) 1949, 17:28 (March) 1949.

Patients' rooms are fitted with one locker per patient for the patient's personal effects and, to save personnel time and steps, one locker per room is supplied for storage of routine items currently used in room service, comprising towels, soap, linen change, bedpan, urinal, brushes, wash cloths, and so on. In the 21 to 27 bed and 35 to 42 bed plans the medical library space on the second floor may serve a number of purposes, including lectures to nurses or personnel, and for board and committee meetings.

Each of the plans will admit of moderate enlargement for additional patients.

In the obstetrics department, which at best is a kind of "no man's land," fixed *fronts* to patients' rooms have been omitted. This is intended as a construction economy and should tend to lessen operating cost by rendering the department simpler for nurses and staff members to supervise.

Also, why close the women in? Naturally they like to feel that they are part of what is going on in the department. It is intended that a canvas curtain, of the kind used in multi-bed rooms, may be installed at moderate cost in lieu of masonry and plaster and door to corridor.

It is intended that sectional (primarily, door height) partitions, not integrated with permanent construction, would be used in the administrative and treatment areas and elsewhere so far as practicable. Modern sectional partitions will tend to simplify some of the problems entailed in possible need for future rearrangements of space.[2]

A thought which invites review is: Will the hospitals we plan today be as comparatively obsolete a quarter century hence as is the common run of hospitals which were built since 1920 when judged by today's standards and requirements? There seems little reason to believe that the transitional period of hospital planning and construction, and methods of operating and treatment of the patients' ills—or anticipated ills—has ended or that these functions have now reached the pinnacle of perfection on earth.

[2]Blumenauer, George: Obsolescence Problems in Hospitals. Southern Hosps. **16**:33 (August) 1948.

Extramural Hospital Services

E. M. BLUESTONE, M.D.
Director
Montefiore Hospital
New York City

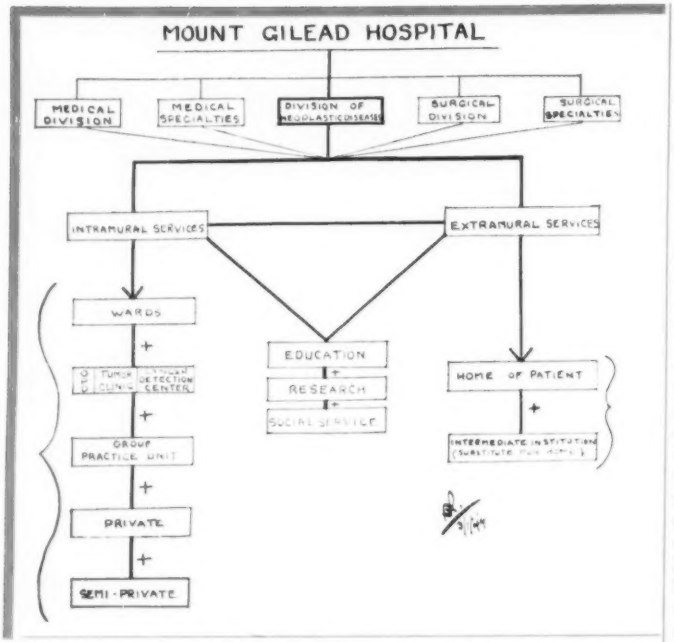
THE hospital, handicapped by its structural rigidity, self-satisfaction and the possession of high grade scientific facilities that are without competition, is beginning to soften its shell. We now behold it emerging as a more vital messenger of medical relief in the surrounding community than ever before. Where formerly the hospital functioned somewhat forbiddingly, mechanically and with an excessive amount of exclusiveness, relieving obvious signs and symptoms if the process was not too prolonged in point of time, it is now reacting to the outer world with more than restrained conformity with the letter of the law. "Come unto me all ye that are weary and heavy-laden" is best interpreted broadly and people are beginning to find the hospital more approachable as it reaches out to take their homes under its protecting wings.

It is only fair to add that hospital economics alone is not dictating this profitable, and very desirable, change in attitude. Hospital authorities are realizing that, even under the most favorable circumstances, whatever they may subtract, they cannot help adding insult to injury when they withdraw a sick man from his home and transfer him to an institution. Any way the matter is viewed, they can do much more good with the superlative scientific facilities of the hospital by making them available to the patient in his natural environment, where his bed is located as a matter of good habit. The cold, impersonal, charity wards of the hospital are no match for the warmth of home care, unless they are urgently needed for those who require (a) what is popularly referred to in hospital language as a "workup"; (b) a period of close observation for a limited period of time under the highest scientific auspices in the concentrated environment of a hospital; (c) major surgery, or (d) such other non-transportable treatment facilities as radiotherapy, in which case there is no choice.

The intramural service which the hospital renders must, by its very nature, be built around the mechanical sciences and most of it is given by doctors on a voluntary basis. The hospital patient who is confined to its intramural wards remains forever a stranger to those who serve him, except for a brief period of time when his signs and symptoms, and not necessarily he himself as an individual, are the object of their attention and this attention is too often exhibited to public view as if it were one of the penalties of ward care. Any suggestion of home care must carry with it a program for the improvement of ward care since we naturally want the best in both branches of hospital service. Our method of attaching a social worker to the house officer for family interviews about the ward patient's condition is a step in this direction.

We know now, as the result of our successful extramural home care program at Montefiore Hospital, New York City, during the last two years, that patients can be cured faster and made to live longer and more comfortably. They benefit from the illusion that the distant hospital exists for them alone when they enjoy the benefit of care under an extramural program which radiates hospital service to them in their homes. Unhurried medical service is available to them on a full-time, round-the-clock basis.

If a bed in the home can be acquired by the hospital inexpensively (in our program, at one-fourth of the cost of hospital maintenance) and dealt with inclusively, it can form an important



1. Mount Gilead Hospital is still nonexistent. Its name was selected because much of the balm, according to the Bible, came from Gilead.

2. The divisions listed at the top of the sketch were selected for purposes of illustration only. They are by no means complete.

3. The Division of Neoplastic Diseases was selected for the special purposes of this graph because it combines medicine and surgery and therefore lends itself more readily to the illustration of the proposed plan.

4. "Intramural services" are services rendered within the walls of the hospital on hospital grounds.

5. "Extramural services" are services rendered outside of hospital grounds.

6. The five subdivisions of the intramural services are intended to represent all of the patient activities conducted on hospital grounds.

7. The group practice unit for the insured group (in cooperation with the Health Insurance Plan of New York) is the counterpart of the outpatient department for the indigent group.

8. Private and semiprivate include the offices of full-time members of the medical staff on hospital grounds.

9. The intermediate institution (substitute for home) is a nursing home, "chronic" hospital, home for incurables, home for the aged, almshouse, poor-farm, as well as such substitutes for the patient's home as the home of a relative or friend.

10. Education, which both hospital services share, includes all kinds of medical education either in a university hospital, a hospital affiliated with a medical school, or through independent teaching.

11. Research, which both hospital services share, draws on all of the laboratories of the hospital, stationary and portable.

12. Social service for both services was selected for special exhibition in this drawing because it plays a vital part in both services and helps to integrate them.

13. The horizontal line between "intramural services" and "extramural services" indicates that there is a free exchange of patients between the two.

14. This diagram in larger communities should be multiplied in such a way that one hospital discontinues its service where the next hospital is prepared to take it up.

15. Although it is not represented on the graph, it is strongly recommended that the Mount Gilead Hospital have a department of social medicine on a par with all other departments.

segment of the total hospital capacity and census.

One of the most important benefits of a complete intramural and extramural program of service is the ability of the hospital, through this wide sphere of continuous usefulness, to relate the factor of medical urgency in the patient to the factor of distance between his bed at home and his borrowed bed in one or another section of the hospital. With this urgency-in-relation-to-distance formula established, and this, by the way, is represented by an inverse ratio (the greater the medical urgency of the illness the less the distance), it is quickly found that the relative number of patients requiring intramural care is less than we have thus far believed to be necessary. This is particularly true in situations where housing is adequate, or can be made adequate by social medical and financial subsidies of various kinds. The demand for prohibitively expensive hospital beds is thus reduced and the hospital is enabled to accomplish two vital purposes: (a) more intensive and highly concentrated intramural service, and (b) hospital service of equal quality to more or less distant beds outside of its walls, which would otherwise stand idle amidst warm and sympathetic surroundings while the patient was admitted to the hospital proper.

An immediate benefit from such a combined program is the reduction in hospital plans for bed expansion which have occupied the minds of hospital authorities so compulsively in recent years. The more extramural beds the hospital acquires, the fewer intramural beds are needed, up to a certain point depending on a few obvious considerations, such as housing, morbidity and the like. It is quite possible that a modernization of existing hospital facilities throughout the country, with a better integration of general and special hospitals, will do away with a considerable portion of expansive and expensive building programs, provided that the extramural possibility is exploited to the limit.

There is another benefit to the hospital, and particularly to the patient, from an extramural hospital program and this is to be found in the ability of the hospital at long last to abolish the unnatural distinctions between "acute" and "chronic" disease which still plague us. In a combined program the criterion for admission is not whether the applicant is "acute" or

"chronic" but whether he actually requires intensive intramural service in a hospital. *His need for this highly concentrated diagnostic and therapeutic service should determine the decision and nothing else.* In this way the hospital can continue to discharge its obligation to those who need intramural service for longer periods of time because they are suffering from prolonged illness, instead of transferring them to "custodial" institutions when they may need hospital care most. All applicants who do not exhibit this need may thus be dealt with in one of two ways: (a) by extramural care at home, or (b) by extramural care in a substitute for the home, such as an intermediate type of institution in which hospital care can still be mobilized. The hospital thus radiates the high quality of its care on a mobile basis in the direction of the patient's home and in the direction of the substitute for his home. In other words, the home, and such substitutes for the home as the home for the aged or for the incurable, "chronic" hospitals, poor-farms, almshouses and the like, would come under the protecting medical wing of the central hospital with a free interchange of patients among them in accordance with the Urgency: Distance formula.

Our demonstration project at Montefiore Hospital began with the indigent, who constitute the bread line at the entrance to any crowded hospital. By studying the social diagnosis and the medical diagnosis side by side, each patient can be classified in accordance with his intramural or extramural requirements. During the experimental period, because of the factor of safety which this precaution guaranteed, we required a work-up in the wards of the hospital before extramural care was arranged. We have found, however, that some applicants who apply for social reasons more than for medical reasons—the extreme case being absolute homelessness—can often be dealt with extramurally without excessive delay. In these situations the Department of Home Care serves, in effect, as an auxiliary to the admitting office. This removes from the intramural service one of its worst pressures and thereby reduces the need for more intramural beds. After medical selection for extramural care, the medical social worker takes over and determines whether the patient's home is conducive to extramural service, psychologically, physically and otherwise, or can be made conducive by subsidy of one kind or another. Our experience has shown that the home can be made adequate in approximately one out of two cases.

For the one who is, for all practical purposes, homeless, there is the substitute for the home. This may be the home of a relative or friend, with or without subsidy, or an intermediate type of institution which is of a custodial character. If it is the latter, the patient can still have the benefit of a radiating extramural hospital program extending in his direction and embracing him with its protecting arms. At the present time, the independent medical staff in this type of institution is found to be well meaning but hopelessly handicapped in a variety of ways. Besides, patients in these institutions, many of them suffering from prolonged illness and by no means "custodial," require much more medically as well as socially than they are able to obtain in this way. Response in these institutions when the patient calls for help is not enough. Of all phases of illness this one often requires scientific care most. There is no *medical* substitute for the scientific care which an extramural hospital program can extend to these patients, even though there may be a *social* substitute for the home of the patient in such intermediate institutions.

Our demonstration project began with the indigent. The problem becomes simpler as the patient rises in the economic scale. The health insurance plan for the middle class in New York City already includes a home-care program which, at its best, is on an extramural hospital basis. Our next effort will doubtless be directed to the economic group which can afford the fees of a private physician and no additional fees, and for which a complete extramural hospital program will be available on a cooperative basis. That this will bring the paid practitioner closer to the superb facilities of the modern general hospital goes without saying and he is bound to benefit by the association.

Working in the only voluntary hospital of its kind in existence, we have seen the social and medical aspects of prolonged illness, in relation to the entire problem of medical care, in the best laboratory of its kind, and these are our conclusions. We find that the sick and the near-sick can be provided for by the community regardless of age, economic condition, duration of illness, phase of illness, address or any other factor by the employment of one or more central hospitals which radiate a high quality of care in all directions. Moreover, the achievement which this combined program represents in the field of social and environmental medicine is beyond price. The more we reflect on the possibilities the more social and medical avenues do we discover for further exploration.

The combined plan is a boon to the patient, to the philanthropist and to the taxpayer for it is hospital economics at its best. By this plan, we can redistribute our superficial, suppressed and hidden social and medical assets in a manner that will bring greater benefits to greater numbers. Here is a free gift to medical education and to medical research, since the teaching and investigative opportunities in the combined program are multiplied in a manner that will keep the beneficiary of hospital effort under observation for unlimited periods of time. A better prepared practitioner of medicine is one of the benefits that we can expect when we view the patient and his needs broadly in this way and, if we proceed with statesman-like effort, we can still prove to the world that humanity can solve at least this problem through individual and collective effort on a voluntary basis.

ADMINISTRATIVE CAPSULES

STRUCTURE does not beget function. Please remember this when you plan for the sick.

THE CONTINUOUS, unhurried and tenacious characteristics of full-time medical service in hospitals are being recognized more and more for their great value and, as the idea spreads, the long-term patient becomes an added beneficiary of the services of these men.

AN EXTRAMURAL HOSPITAL PROGRAM will yield more facts and figures for planning purposes over an experimental period of time than any other known form of survey for these purposes.—E. M. BLUESTONE, M.D.

F.C.C. rules and regulations on

DIATHERMY and TELEVISION

prevent chaos in radio communications

HOWARD A. CARTER
Secretary
Council on Physical Medicine
American Medical Association
Chicago

THE Federal Communications Commission has announced rules and regulations regarding the manufacture and use of diathermy equipment. At first glance one wonders why the commission would want to have anything to do with a medical procedure. To the novice it seems like one more indication of governmental interference in medicine. However, the activities of the Federal Communications Commission in this instance are justifiable and necessary in order to prevent chaos in radio communications.

For example, a diathermy apparatus which is not frequency-controlled might be used in an apartment building at the same time a resident in an adjacent apartment on the same floor or one floor up or down might choose to operate a television receiver. The distance between the diathermy equipment and the television receiver might conceivably be the thickness of the partition, or at the most several feet. A partition between two apartments is no barrier to radio energy although the partition might establish secrecy and prevent transmission of ordinary sound.

MIGHT CAUSE INTERFERENCE

Without knowing it, therefore, the physician might interfere with the television and cause considerable annoyance to the neighbor. As a matter of fact, the neighbor might be one of the physician's patients or, again, the neighbor might be his own family or a colleague. It is not likely that a physician who owns a diathermy apparatus would wish to interfere with the pleasure of his patients or a colleague. Putting it the other way, a third physician operating a diathermy apparatus might interfere with the first physician's television set.

On May 9, 1947, the Federal Communications Commission released Public Notice 7722 entitled "Order With Respect to Medical Diathermy and Industrial Heating Equipment and Notice of Proposed Rule-Making With Respect to Miscellaneous Equipment."

This document assigned three frequencies, in harmonic progression, for medical diathermy and industrial heating. Channels are 13.66, 27.33 and 40.98 megacycles, corresponding to approximately 22, 11 and 7½ meters wave length, respectively. The widths of the channels are approximately 15, 320 and 40 kilocycles, respectively. Harmonic and spurious radiations on frequencies other than those specified shall be suppressed so that radiation does not exceed a strength of 25 microvolts per meter at a distance of 1000 feet or more from the diathermy equipment causing such radiation.

Another channel has been assigned, namely, 2450 megacycles, corresponding roughly to 12.2 cm. wave length. A frequency in the neighborhood of 6 megacycles will be announced later and frequencies of 915, 5850, 10,600 and 18,000 megacycles have also been allocated for industrial, scientific and medical use.

At present the commission has not found it necessary to make any rules applicable to surgical diathermy.

The commission ruled that all diathermy equipment manufactured in the future shall meet these regulations if the equipment is to be used without a license. Manufacturers may now receive "type-approval" of the equipment if it meets the rules and regulations of the Federal Communications Commission. Using a type-approved apparatus, a physician need not obtain an operating license. If a physician is using existing equipment operating on a frequency not assigned, shielding must be employed and certification obtained. This rule refers to apparatus that was purchased prior to July 1, 1947.

The rules and regulations of the Federal Communications Commission indicate that there are generally two methods of operating diathermy equipment in compliance with the rules for equipment manufactured after July 1, 1947. The first method is to operate within assigned frequency bands using equipment that is either "type-approved" or certified by a competent engineer in accordance with the applicable sections of the rules. The second method is to operate on any frequency provided the equipment is in a shielded room with a filtered power supply and all radiation on any frequency is limited to 15 microvolts per meter at a distance of 1000 feet or more from the diathermy equipment. Operation in this manner also requires certification by a competent engineer.

MAY CONTINUE FIVE YEARS

A physician who owns and operates a diathermy apparatus manufactured prior to July 1, 1947, may continue to operate for a period of five years, provided the equipment does not interfere with authorized radio services. If interference is reported, the physician is responsible for eliminating the disturbance to radio communications. This can be accomplished in some instances by readjusting the existing diathermy appliance. If no means can be provided to eliminate the interference, then the physician becomes subject to the new rules and regulations. That is to say, he must screen the apparatus or acquire frequency-controlled equipment immediately.

More than 10 years ago the Federal Communications Commission was requested by several radio communication agencies to formulate regulations to control man-made interference caused by diathermy equipment. When short-wave diathermy was first marketed, the wave lengths employed were so short that the manufacturers did not anticipate any serious complications. In other words, that part of the radio spectrum used by diathermy was outside the region then

generally employed for communications.

It was not long until the amateur radio operators were using these channels for communications, and they observed interference originating from diathermy equipment. The problem would not have been so confusing had these radio-frequency energies been restricted to two or three channels; but the manufacturers of diathermy equipment, being guided by the early clinical investigators, selected channels of several lengths for therapeutic purposes. Time and effort in research eventually established the therapeutic value of the physical agent. The Council on Physical Medicine of the A.M.A. reached the opinion after careful study that short-wave diathermy was another means of applying heat to a patient and that it did not matter what wave length between 30 and 5 meters was employed.

As radio communications expanded and more channels were needed for such services as ship to shore, airplanes to ground, police station to squad car, and countless governmental and private services in the interests of the public, nearly all available channels have been assigned for such purposes.

Television was assigned channels and it became an important factor. Diathermy interfered with television in some instances, making the picture in the television receiver indistinguishable.

While the manufacturers of diathermy equipment had no desire to make apparatus that would interfere with communications, there seemed to be no simple solution. Screened rooms were suggested, but they were high priced and inconvenient to install. This is a room lined with a metallic substance, such as a copper screen or iron plate. Except in rare instances, screening diathermy apparatus to prevent interference was ruled out as expensive and cumbersome. There would be no interference if all of the radio-frequency energy generated by diathermy could be used efficiently for treatment purposes. Unfortunately, diathermy apparatus has not been developed that will not radiate energy into space.

In the meantime, radio-frequency energy for industrial purposes had come into general use. Since the demands for communication channels were so great, considerable pressure was put on the Federal Communications Commission to provide as many channels as possible. Fortunately, all diathermy apparatus can be operated on the same radio channel, or channels, and there is no interference of one unit with another. Hence, the interference problems of diathermy and industrial heating were considered one and the same by the commission.

Many installations of diathermy apparatus are used in steel buildings. The buildings themselves in many instances act as shields, and interference with radio communications is greatly reduced. It is relevant to mention that screening may not always act effectively as a shield when there are breaks or openings in the screen. Poor contacts along the door jamb may permit excessive amounts of leakage and thereby cause interference over long distances.

The question has been asked: "Can an uncontrolled diathermy be changed over?" The answer is "yes" but the expense involved and the trouble encountered are so great that it is cheaper to buy a new apparatus which is approved by the F.C.C. and accepted by the Council on Physical Medicine.

Some discussion has been raised as to the relative merits of (1) the health of the nation and (2) the protection of the public by the police. While a physician may be treating a disease, the police might be hampered in protecting the property of the public by interference caused by a diathermy apparatus. Fortunately, problems of this nature, if indeed they exist, can now be overcome by compliance with the regulations of the Federal Communications Commission.

Maids' Cart Saves Time and Supplies

MANY hospital housekeepers have found a real need for a small, compact, quiet truck for maids' use on the patients' floors. Beth Israel Hospital in Boston attempted to purchase such a cart but without success. Trucks for hotel and hospital use were manufactured and readily available but either they were too large, or they provided space for various articles not used, or they were too expensive for our needs. Therefore, we decided to manufacture a truck within the hospital tailored to our specific problem. The cart was designed and built in the hospital and has proved to meet all the demands of the housekeeping department.

Small, quiet and compact, the specially built cart saves maids' time and hospital supplies.

The employes feel the hospital truck is excellent because it saves so many steps for them. In turn, the housekeeper has found less loss of cleaning materials on the floors, as well as more economical use of what is given out each day. Every evening the carts are inspected by the housekeeper, refills are made, and the trucks are left in a locked room. This daily review by the housekeeper has done much to promote economy by the employes. The waste bags which are attached to the front of the cart with grommets and hooks are made of green cotton herringbone which can be laundered easily. Another feature of the truck are the mop hooks located at the opposite end from the waste bag.

The carts were constructed of 1 inch pine stock, stained and varnished and equipped with four swivel 3 inch plate casters.—MRS. JUNE MALONE, *executive housekeeper, Beth Israel Hospital, Boston.*

THE STUDENT'S JOB ON THE NURSING TEAM

is to learn to be a good nurse

HARRIETT R. BERGER, R.N.

Medical Instructor-Supervisor
St. Luke's Hospital School of Nursing, Chicago

THE rôle of the student nurse on the nursing team is dependent on several factors: the qualifications and experience of the various team members, the method of assignment used and the skill with which it is made out, the amount of supervision available, and the place of the student in her clinical program, whether first, second or third year. A hospital which accepts the responsibility of a school of nursing recognizes that the primary purpose of that school is to prepare its students for the professional practice of nursing in the community at large. It is this responsibility to society that must be kept in mind as the students' clinical experience is planned, for society will benefit the most when the nurse is graduated secure in her knowledge of fundamental facts and principles, skillful in her analysis of nursing problems and in her ability to solve them, and sensitive to individual social values.

WARD EXPERIENCE INVALUABLE

The hospital wards provide an invaluable laboratory for study and practice. They may be used to the greatest advantage by the well planned assignment of students to clinical experience. Clinical practice is concerned with the art of applying the scientific principles of nursing to the care of patients. In the classroom the student learns about nursing, but it is at the bedside of the patient that she develops her skill in giving nursing care. It would be a great mistake, however, to assume that mere practice will make a perfect nurse. The value of clinical experience lies in the possibility of the student's being able to practice good nursing. It is only intelligent, thoughtful and correct practice that will produce intelligent, thoughtful and expert nurses.

We have found, through experience during the past few years, that the use of auxiliary workers can be a great help in planning good clinical experience for students. With their help students can be protected from the pressure of speed by being given smaller assignments. Four or six patients can be given really good care during a student's morning hours on duty, but only a very inadequate and superficial job can be done when the assignment is 10 or 15 patients.

There are two methods of assignment possible when all of the members of the nursing team are used. The first method, and probably the more desirable for most occasions in the light of good student education, is the assignment of a graduate nurse, a practical nurse, a nurse's aide, and possibly a maid, to a group of patients. In this situation the graduate acts as team captain, assuming leadership responsibilities for the welfare of all the patients in the group. She gives the necessary professional care to the seriously ill and critical patients, passes medications, and does the more complicated treatments. The practical nurse gives care to the chronically ill and convalescent patients, and does the simple treatments, while the nurse's aide assists with the bed baths and bed making. If a ward maid is included on the nursing team she does the cleaning of the units, gets fresh water for the patients, and goes on the necessary errands.

Where this type of assignment is utilized the student's assignment should be entirely apart and separate. The patients of greatest educational value should be assigned to the students on a case method basis. A young student is not ready to assume the leadership or responsibility of team captain, nor does she learn how to give individualized care to her patients when the nursing duties are as functionalized as this type of assignment makes necessary.

The use of the group assignment provides an efficient means for giving good nursing care to a large number of patients, and makes the assignment of a limited number of patients to the students possible. It is an especially happy solution when we remember that those patients who are of greatest educational value for the students are almost always those who would benefit the most from the individualized attention of a carefully supervised, enthusiastic student nurse.

With this type of assignment the student's learning experiences can be chosen for her as she is ready for them. Her assignment can be small enough so that it will be possible for her to get to know her patients as people, to learn their diagnoses, their family problems, their hopes, their worries, their plans for the future. She can be given help in learning how to apply the principles she has learned in the classroom to these individual patients. She can be shown how to plan health teaching programs for her patients, and given time to carry out such programs. She can be taught to observe her patients' nursing needs, solve the problems they present, plan how to meet the needs, carry out the plan, and evaluate the results.

PATIENTS SUFFER CONSEQUENCES

All of this—and this is what good student education involves—can be accomplished by proper assignment and supervision. By contrast, when the student is given too large an assignment, with too much responsibility, too many patients, and too much to do, she becomes confused and disorganized and not only her work but her patients suffer.

The other possible method is to assign the graduates and students to specific patients with the practical nurses and nurse's aides assigned to do certain things for definite patients under the supervision of the graduate or student. This type of assignment has certain advantages and certain disadvantages. The disadvantages are

Presented at the Tri-State Hospital Assembly, May 1949.

that the students have a tendency to lose sight of the patient as a person and to concentrate on getting a certain number of procedures and treatments completed in a given length of time. Without full responsibility for the patients assigned there is also a tendency to accept little or no responsibility for the completion of the patients' care. The answer the head nurse is likely to receive is, "I thought the aide did it," or, "the practical nurse said she was going to do it." One of the advantages of this method of assignment is that it provides an intermediate step in the adjustment of the older student who must eventually learn how to work with all of the various members of the nursing team. In this respect it is of most value during the experience of the senior student.

During the last few months in the school the student should be ready to make the transition to the type of assignment where she assumes responsibility, as team captain, for the total care of a group of patients, and functions as leader of the team. This experience can be of great educational value for senior students, especially if they receive sufficient guidance and good supervision.

Schools of nursing should welcome the trend toward the use of the nursing team. The services of the professional nurse, the practical nurse, the nurse's aide, and whenever possible the ward maid, can be utilized to a large extent in making student assignments of greater educational opportunity. The rôle that the student plays as a member of the nursing team can mean better student education and can result in better qualified professional nurses.

The day of harried students rushing to complete impossible assignments, and uncomfortable, discontented patients waiting for hours in the middle of a bath may be over. Instead it is possible, through the use of the nursing team, to have well planned, educationally valuable student assignments, and well cared for, happy patients. This goal is within our reach, but there is a note of caution—the team must be used correctly, assigned carefully, and the students' experience must be zealously guarded.

Twin Cities Hospitals Tell the Community

ON two occasions recently the citizens of St. Paul and Minneapolis have had an opportunity to learn about their hospitals: what it costs to operate them; the average length of stay, and how Blue Cross helps with the hospital bill. The photographs tell the story of the efforts made to interpret the hospitals' problems to the public in Minneapolis at Asbury Hospital's open house display, and in St. Paul on National Hospital Day.

The picture at the left shows the lobby display which Asbury Hospital put up in observance of its twentieth anniversary. The small poster gives statistics about patients, length of stay, babies born and operations performed at Asbury in 20 years. The first large poster shows an enlarged copy of the Minnesota Blue Cross identification card for subscribers. The second poster shows two recent Blue Cross patients at Asbury and copies of their hospital bills.

The man in the lower picture is also the patient on the right who is viewing the display. His bills made an especially good showing since he has been ill a long time and has already used two of the 70 day periods provided for care each contract year. Asbury wanted to show what Blue Cross does for hospital patients.

The picture at right shows one of the window displays which were put up by St. Paul hospitals as part of their Hospital Day observance. The hospitals' theme this year was hospital costs and why they are high. Open house was held by most of them, with posters in the lobbies, and various pieces of equipment around the hospital labeled as to original purchase price and cost of upkeep. They also jointly released a story to the local newspapers regarding hospital costs.—MARGARET REAGAN, *public relations manager, Minnesota Hospital Service Association and Minnesota Medical Service, Inc., St. Paul.*

Open house at Asbury Hospital. The patient and Rev. Walter Vater, chaplain, view the display.

Window display in the First National Bank Building of St. Paul put up to celebrate Hospital Day.

Exterior view of the Cullen Nurses' Building, Memorial Hospital, Houston. The seven-story fireproof building, located downtown near the civic center, is a block long.

JOHN G. DUDLEY
Administrator
Memorial Hospital
Houston, Tex.

Home Was Never Like This

BEAUTIFUL, elaborate . . . the finest building of its type in the South . . . superlative in its appointments and suitability to offer the finest accommodations to student nurses."

In these words, architects, contractors and medical authorities alike describe the recently completed $2,000,000 Cullen Nurses' Building of Memorial Hospital, Houston, Tex.

The seven-story building, located in downtown Houston near the civic center, is a dream fulfilled for the board of trustees and personnel of the hospital. But not until Mr. and Mrs. Hugh Roy Cullen, Houston philanthropists, gave $1,000,000 to the hospital "to make nursing the most sought after profession in the United States" was the building made possible. The two benefactors gave an additional $1,000,000 to Memorial Hospital to complete the nurses' building at the dedicatory ceremonies.

The block-long fireproof building, which officials hope will set the structural pattern for a proposed parkway plaza to extend about five blocks from the City Hall, is constructed of limestone, cast stone, and brick veneer. Framework is of reinforced concrete.

While the building has seven stories, two additional floors have been added to house the elevator shaft and other required machinery. Two high speed automatic push-button elevators serve the structure, which has over-all dimensions of 227 by 118 feet. Upper floors are recessed to provide maximum light and ventilation.

Entrance to the main lobby and lounge, paneled throughout in red oak, is through wide modernistic glass doors, set in frames of corrugated, sand-blasted glass face.

Many art objects have been placed throughout the lounge, with special emphasis being placed on several Chinese pieces. The floor is covered with 19 by 33 foot cocoa brown rugs, all original handloomed V'Sosike creations. This same firm recently created the floor covering for the Green Room in the White House in Washington.

The ceiling has been treated with acoustical plaster which helps greatly in deadening sound.

The residence lobby leads to classrooms, laboratories, the library and other rooms associated with the nursing school. The hostess' office is located near this lobby.

At still another entrance, around the corner, one finds the guest lobby with a music section at one end and a live fireplace, main mailboxes and a hostess desk.

Over the fireplace is hung one of the two unusual murals found in the building. The other is on the wall near the entrance to a spacious auditorium on the first floor. Both murals were executed by Pierre Bourdelle of Paris, France, and New York.

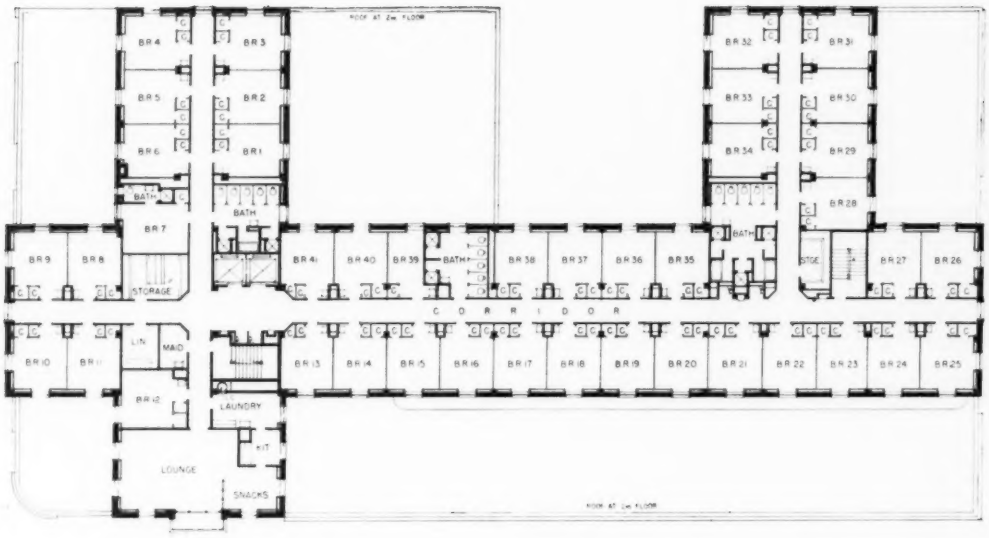
On each side of the fireplace are lime-green love seats and facing it is a 13 foot green quarter circular sofa. Immediately in front of the sofa is a circular coffee table with a plant recess in the center. The table is made of heavy oak, treated with red lacquer mixed with silver. Gaily colored chairs and settees are scattered throughout the room.

On another side of the lobby is a section with a grand piano and many massive and small chairs and sofas designed for comfort and informal living.

Five reception rooms, already nicknamed "date rooms" by the students, are separated from the main lobby by corrugated, sand-blasted glass partitions. Each is decorated and furnished in a different color. Chinese modern draperies are used throughout and their color schemes blend with the predominant color of the "date rooms."

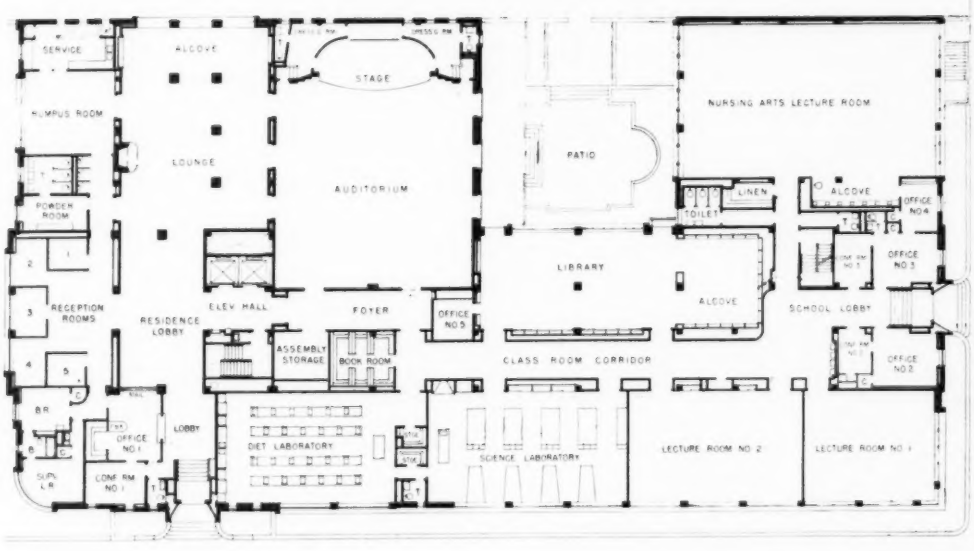
At one end of this section are two guest sleeping rooms, each with attached bath and furnished with comfortable elegance.

William J. MacMullin, interior decorator, who directed the furnishing of the building, has kept pace with "the most symmetrically modern" theme of the structure.



TYPICAL FLOOR PLAN

Plan of the first floor (below) shows the layout of the lobby, lounges, auditorium and reception hall and the nursing arts lecture rooms. Above: A typical floor showing the grouping of the bedrooms and the facilities for laundering, as well as floor lounges and snack rooms.



FIRST FLOOR PLAN

The reception lounge as seen from the front entrance. Many art objects have been placed throughout this lounge with special emphasis on several Chinese pieces.

The floor of the main lounge is covered with 19 by 33 foot handloomed V'Sosike rugs. Over the fireplace is hung one of the two unusual murals in the building.

Above: The library measures 23 by 66 feet. Opening off it is an enclosed patio with tropical shrubs and fountain. Below: Each floor lounge is different.

Above: The dietetics laboratory is equipped with individual gas stoves. Below: Their "distinctive styling" takes students' bedrooms out of the dormitory class.

In all, the building has accommodations for 252 nurses in training, with living quarters provided above the main floor. Work and study rooms, including two large lecture rooms, complete laboratories and a library, are located on the main floor. The library, measuring 23 by 66 feet, will be one of the most nearly complete reading and study rooms in any nursing school. The larger of the lecture rooms is the 37 by 64 foot nursing arts lecture room which is supplied with ample blackboard space and a rostrum.

Special emphasis will be placed on visual education, now considered a prime requisite in the teaching of any subject. A smaller classroom is equipped to handle graphic lectures for the specialized fields of nursing education.

Students will get actual practice in the many phases of laboratory work in the completely equipped science laboratory.

The diet laboratory is equipped with individual gas stoves so that students are afforded the opportunity to learn by doing.

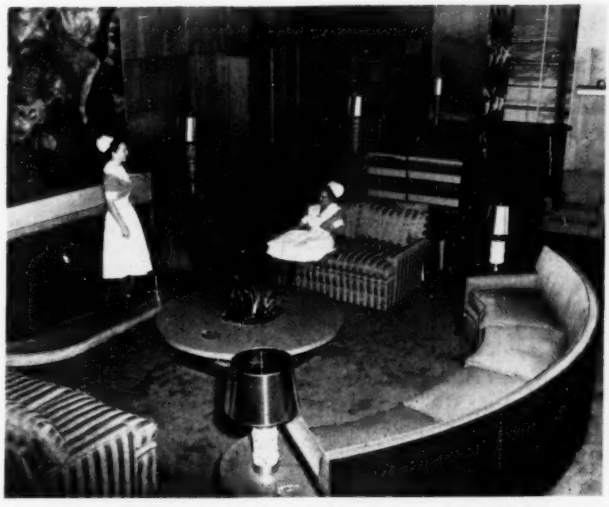
Still another center of attraction on the first floor is a birch-paneled auditorium, measuring 60 by 48 feet and seating about 300.

Walking or riding to the floors above, one sees that each floor is decorated and furnished in an individual manner. One section of the sleeping quarters has been set aside for nurses on night duty. This section is darkened; the amount of light that seeps into the corridor is minimized to give the daytime sleepers the utmost opportunity for uninterrupted sleep.

Designed to bring added comfort to the students are the lounge rooms located on each floor in the nurses' quarters. Beauty as well as utility were injected into the planning of these rooms, while an innovation is the distinct furnishings and coloring of each. A typical lounge measures about 28 by 18 feet. In this particular room, a gold "silky" chenille rug is centered on the floor. The walls are decorated with wallpaper depicting "Gay Nineties" scenes. The scenes show figures, marquees of famous restaurants and rendezvous associated with the colorful period of our history. All appear to be drawn in crayon on an off-white background. A solid charcoal ceiling seems to add the frame for the room.

Furnishings in the room include large and small sofas, covered in soft

Inside lounges or sitting room, with date rooms opening off them.



Above: Closeup of the fireplace showing mural and 13 foot sofa.

Below: Each floor is provided with a laundry—for clothes and hair.

The smaller of the two classrooms is equipped with visual education materials so that graphic lectures can be given in the specialized fields of nursing education. Comfortable chairs and good lighting make classwork less of a burden.

contrasting colors. Deep, comfortable chairs contrast well with the trim lines of other seating places. A huge glass-topped coffee table, convenient to a brace of love seats, gives a modern contrasting effect to the "Gay Nineties" period. The table is constructed of solid myrtle burl.

Still another modern touch in the room is the console radio and record player, standard equipment in all the lounge rooms. Heavy draperies outline the windows, creating a soft effect that enhances the beauty of the room.

In keeping with the distinctive styling of the lounge rooms, each floor of the nurses' quarters, starting with the general hallway, is furnished and decorated individually with certain colors and color combinations predominating.

It is this "distinctive styling" feature of the decoration of the building that takes it out of the "dormitory" type of structure and puts it in the "homey-good living" class.

At the end of each of the lounge rooms is located a "snack room," separated from the main room by an individual open partition comprising turned wood poles with small "what-not shelves" spaced at different levels. The floor in each of the snack rooms is linoleum over a base of heavy felt to minimize sound. Equipment in each consists of an individually designed table that opens to unusual proportions, and ample stainless metal tubing chairs which are upholstered in gaily colored leather.

Just off this room is a small kitchen providing ample space for preparation of "off-hour" snacks which are always associated with nurses' homes or wherever students gather. "A kitchen in a package," as the manufacturers call them, a gas stove, sink, cupboard space and a refrigerator are housed in a minimum of space and can be completely enclosed in white enamel doors. The drainboards and shelves of the compact kitchens are built of steel and have an enamel finish.

Still other facilities, designed to meet the comforts and needs of students, have been installed in the building. Notable among these are the laundry rooms on each floor of the nurses' quarters. These rooms are located next to the snack kitchens and can be reached through connecting doors. In each of the small laundries are washing facilities and ironing boards arranged with drying facilities of adequate proportions.

To give the building a seashore touch, colorful deck chairs and lounges line the upper floors. These sun decks are located on the third through the seventh floors and permit recreation and sun bathing without observation from the streets or the correspondingly high buildings in the area. Atop the six-story south wing of the building are planned shuffleboard and badminton courts and facilities for quoits and other games.

A complete recreation room, measuring 50 by 88 feet, is located in the basement of the building. This room will provide facilities for many games indoors during inclement weather. In addition, the room provides a larger gathering place for entertainment. It is served by a completely equipped kitchen, while a dumbwaiter connects with the serving pantry on the first floor.

Already a striking building by virtue of its streamlined construction, the Cullen Nurses' Building will become even more beautiful when landscaping plans have been completed.

Connected with the main hospital by a tunnel under the street, the building is the latest addition in the hospital's ambitious expansion program and another link in the chain of progress of Memorial Hospital that began in August 1907, when a two-story frame dwelling, known as the Rudisell Sanitarium, was purchased by Houston Baptists for $18,000, then an "unheard of" price.

With a board of trustees formed, the building became known as the Baptist Sanitarium, with the late Rev. D. R. Pevoto, one of the founders, becoming manager. The name of the building was changed in 1922 to Baptist Hospital, and in 1931, the name of Memorial Hospital was adopted.

Since its purchase in 1907, the hospital has grown from 18 beds to its present capacity of more than 300.

The school of nursing, chiefly under the guidance of Mrs. Lillie Jolly, former nursing director for whom the present nursing school is named, has grown also. Since 1907, the school has graduated 905 nurses. Ninety-seven Memorial nurses served in World War II.

Architectural design of the building was conceived by Kenneth L. Franzheim, Houston architect. The general construction contract was handled by the American Construction Company, Houston. The building site had been donated by Mrs. J. W. Neal, a prominent Houston Baptist, civic worker and philanthropist. The land, covering one full city block, was valued at $400,000.

FEDERAL HOSPITALIZATION

II—CURRENT TRENDS

ELI GINZBERG
Columbia University

IF A review of the rather distant past had relevance for an appraisal of the present status of federal hospitalization and the prospects for its future,* then a review of the more immediate past, of the changes brought about during the recent war, has heightened pertinency. The impact of the war on federal hospitalization, particularly on the expansion of the medical services of the armed forces, has not been evaluated. And yet World War II brought about a series of changes in federal hospitalization of such magnitude that they can only be described as revolutionary.

In 1939 the hospital structure of the federal government, measured in terms of the four principal agencies, Veterans Administration, army, navy, and Public Health Service, numbered under 100,000 beds, including about 15,000 domiciliary beds of the Veterans Administration. To discharge its responsibilities for hospitalization and to meet all of its other requirements in the fields of preventive medicine, research and education, these four agencies together had fewer than 5000 doctors on military and civilian status.

EXPANSION WAS AMAZING

The expansion of this system during the period of mobilization and, more particularly, during the period of hostilities was truly astounding. In the spring of 1945 when the Germans surrendered, the total hospital plant of these four agencies approximated 800,000 beds. This eightfold expansion in facilities was paralleled by a much larger expansion in medical personnel. On V-E Day, the federal government had on its rolls approximately 65,000 doctors, the vast majority of whom were in the armed services.

Since the scale of medical operations at the height of the war has seldom been appreciated, even by those who were active participants, a few additional data might prove illuminating. Since the largest part of the expansion took place in the army (which throughout the war and until recent date provided medical services to both the army and the air force), the illustrations have been selected from the experience of the medical department of the army. In 1939 on a typical day the army had a total of approximately 10,000 patients in its hospitals within the continental United States and in all of its overseas bases. In 1945 there were more patients on the rolls of a single large hospital center than there had been in all army installations six years previously.

At peak, the army operated throughout the world 1000 hospitals with an average daily census of just under 600,000 patients. To meet this responsibility the army had available approximately 45,000 doctors, 55,000 nurses, and a total personnel complement of more than 700,000. This meant that with 600,000 patients and 700,000 medical personnel, the medical department of the army was responsible for more than 15 per cent of the total strength of army and air force combined. Added to this responsibility was the army's evacuation mission. During the course of the war 500,000 seriously wounded and ill patients were evacuated from overseas theaters to army general hospitals in this country where they received definitive treatment. In the single month of March 1945, there was a *daily* inflow by air and ship of almost 2000 patients.

To cope with the needs of its sick and injured the army constructed more than 450 hospitals in this country on its posts, camps and stations to care for the local troop strength; and in addition built and converted sufficient properties to establish a system of 65 general hospitals — where at the beginning of the war it had had five — which served as treatment centers not only for the evacuees, but also for the soldiers in this country with complicated conditions which could not be adequately treated in station hospitals. During the latter stages of the war the capacity of the general hospital system proved inadequate and the army therefore established 13 large convalescent hospitals. This new and large convalescent hospital system was able to treat successfully about 150,000 patients during the last eight months of the war.

CONTRACTION WAS RAPID, TOO

The expansion of the army's hospital system was exceptionally rapid; so, too, was the contraction. Within a period of 12 months after V-J Day the 600,000 bed operation had shrunk to approximately 100,000; and in place of the 45,000 doctors who had been on active duty, there were only 15,000. Although most of the demobilization was accomplished within this 12 month period, the scale of medical operations continued to decline to a point where in June of 1948 the army and air force combined were operating fewer than 34,000 beds and were performing their mission with fewer than 4400 doctors. The last 12 months have seen a further decline, although one of modest proportions.

As might have been expected, the record of the Veterans Administration was almost directly inverse to that of the armed forces: the period of the war was relatively stable, while a marked expansion has taken place since the end of hostilities. There was a slight increase in its hospital population between 1939 and 1943 from approximately 50,000 to 54,000; and a somewhat more rapid increase during the last two years of the war. However, this increase was more than offset by the trend in the census of

*Ginzberg, Eli: Federal Hospitalization, I—The Setting, Mod. Hosp. 72:61 (April) 1949.

domiciliary patients where a marked shrinkage took place from about 15,000 in 1939 to under 9000 in 1945.

Perhaps more important than these quantitative changes were the qualitative developments. With rather serious deficiencies at the onset of the war in skilled medical personnel, the Veterans Administration suffered serious personnel drains during the early part of the hostilities. Its professional staff volunteered in large numbers for service in the armed forces; and the rapidly rising wage rates in civilian industries and the draft combined to rob it of a large proportion of its nonprofessional staff.

TO KEEP V.A. FROM COLLAPSE

The situation became so serious toward the latter part of the war that the armed forces made strenuous efforts to keep the Veterans Administration from total collapse. Many who had volunteered for duty with the army were placed on inactive duty and returned to the Veterans Administration for reassignment; the army even assigned a considerable number of enlisted men to duty in Veterans Administration hospitals to fill at least some of the gaps resulting from the loss of ward personnel. Finally, the army delayed transfer to the Veterans Administration hospitals of certain categories of patients, particularly those suffering from tuberculosis and paraplegia. These measures, however, were no more than palliatives. They prevented what might have been an almost complete collapse in the medical operations of the Veterans Administration but they were totally inadequate to enable the Veterans Administration to prepare itself for its expanded responsibilities of peace.

The magnitude of these responsibilities can be pointed up by outlining the trends in work load, requirements for facilities, and the needs for much larger numbers and much higher quality of personnel. When the United States entered World War II, the Veterans Administration had varying levels of responsibility for a population of approximately 4,000,000. The expansion of the armed services during the course of the war presaged that this population would total about 16,000,000 in 1945 and that it would continue to grow—as in fact it has—as long as the country requires a sizable military force. In June 1948 the total living veteran population was estimated to be just under 19,000,000, of which almost 15,000,000 were World War II veterans.

Although prior to the end of the war the Veterans Administration had made estimates as to its future requirements for hospital beds; and although these estimates pointed in the direction of a very large total (between 250,000 and 300,000 several decades after the end of the war), little if anything was done to meet even the smallest part of this requirement for expanded capacity. This is not surprising. With materials and labor in exceedingly short supply during the course of the war, it was impossible for the Veterans Administration to secure priorities. A relaxed administration doubtless found comfort in the fact that the end of the war would find a large number of surplus army and navy facilities which the Veterans Administration could use if the need arose. It was realized, of course, that these military hospitals had their limitations. For the most part they were built for temporary use; many failed to meet the minimum standards prescribed by Congress for the quality of facilities in which veterans could be treated.

It might seem surprising that the army, which spent more than a billion dollars on the construction of hospital facilities during the war, gave little if any consideration to the possible postwar use to which these new properties could be put. But the army expanded rapidly, and this meant that its hospitals had to be constructed in the shortest possible time. Moreover, it was imperative to conserve scarce materials, and the materials required for permanent construction were extremely scarce.

Probably more could have been done to integrate the emergency needs of the armed forces and the potential needs of the Veterans Administration. But it is doubtful whether the most effective planning agency could have accomplished very much. As a fact in point, there were only two units constructed for the army, one at Richmond, Va., and the other in Chicago, in which the original plans were drawn with an eye to transferring the hospitals to the Veterans Administration after the cessation of hostilities.

As the war came to an end, the Veterans Administration was able to make a start on its expansion program, but the pressure from the vastly swollen veteran population was far in excess of the modest increase in beds which the initial phases of the expansion program could provide. To procure additional beds in the shortest possible time the first stages of the expansion program were concentrated on erecting additions to existing hospitals. In only two cases were the new beds provided through the construction of new hospitals. Three years after the war's end the Veterans Administration had enlarged its capacity through new construction by approximately 12,000 beds. The major part of the program which Congress had authorized—amounting to about 50,000 beds—was at the end of 1948 two-fifths under contract and about three-fifths still in the planning stage.

Confronted with urgent requests for hospitalization at the end of the war, in the first instance by veterans with service-connected disabilities who were entitled by law to care by the Veterans Administration; second, by many veterans without service-connected disabilities but who required hospitalization because they were suffering from a psychiatric disorder or from tuberculosis and could not obtain it satisfactorily in available state, county and voluntary hospitals, and, finally, with pressure from the more or less "medically indigent" veteran who required general or surgical care, the Veterans Administration was in dire need of additional facilities which it could immediately use.

HOSPITALS FROM ARMY, NAVY

Today the Veterans Administration is operating approximately 28,000 beds in some 30 hospitals which during the war belonged to the army or the navy, primarily the former. Most of these hospitals were acquired by the Veterans Administration in 1946; a few were transferred more recently. Congressional action in the form of relief from stringent standards of construction and often from fire regulations was required before these properties could be put to effective use by the Veterans Administration.

Although the Veterans Administration tried to select the most suitable of the surplus properties, its choice was restricted by the geographic distribution of available army hospitals. The army has been criticized for

(*Continued on Page* 124.)

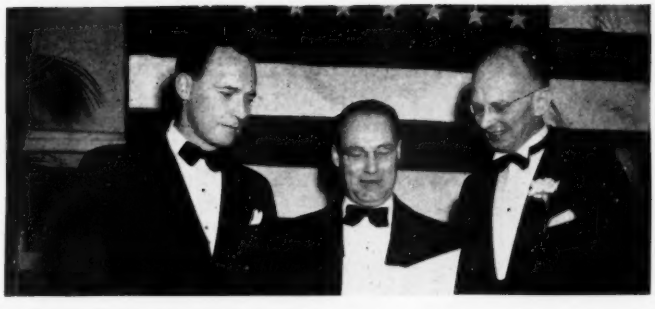
People in Pictures

Yale University administration class visits Grasslands Hospital, Valhalla, N.Y. Front row, l. to r.: Dr. Chi-Fu Peng, Betty L. Horne, John D. Thompson, Henry G. Brickman. Back row, l. to r.: Dr. Clement C. Clay, director of the course; Dr. Arthur N. Springall; Nelson F. Evans, administrative resident of the hospital; Dr. E. L. Harmon, director of Grasslands; Austin J. Evans.

Officers named at the meeting of the Catholic Hospital Association held in St. Louis in June were, left to right: Rt. Rev. Msgr. John R. Mulroy of Denver, who was chosen president-elect; Rev. John W. Barrett, archdiocesan director of hospitals, Chicago, who took office as president, and Rt. Rev. Msgr. H. Joseph Jacobi, of New Orleans, named first vice president.

At the Middle Atlantic Hospital Assembly, left to right: John H. Hayes, superintendent, Lenox Hill Hospital, New York City; Louis Schenkweiler, superintendent, Wyckoff Heights Hospital, Brooklyn, N.Y.; John Olsen, superintendent, Richmond Memorial Hospital, Staten Island, N.Y., and Rt. Rev. Msgr. George L. Smith, past president, Catholic Hospital Association.

The retiring presidents of three state associations (l. to r.): Lawrence E. Kresge, Hospital Association of New York State; Dr. Herbert M. Wortman, New Jersey Hospital Association, and Herman S. Mehring, Hospital Association of Pennsylvania, gather at the banquet of the Middle Atlantic Hospital Assembly's first annual convention.



New graduates of the University of Minnesota course in hospital administration, and three faculty members (James A. Hamilton, James W. Stephan and Dr. Gaylord W. Anderson):

1st row (l. to r.):
Robert Rogers
Dr. Lourdes Carvalho
Jean Conklin
James A. Hamilton
Dr. Gaylord W. Anderson
James W. Stephan
Dorothy L. Petsch
Frederic G. Hubbard
Donald F. Smith

2nd row (left to right):
W. John Dawson, Jr.
Dr. Guillermo Betanzos
John C. Pratt
Richard W. Blaisdell
John S. Henderson
John M. Danielson
John L. Beckwith
Robert B. Carey

3rd row (left to right):
Charles G. Skinner
Robert F. Hoffmann
John D. Taube
Ronald A. Jydstrup
Stanley F. Masson
Walter J. McNerney
Stanley R. Nelson
James L. White
William D. May

Not in Picture
Evelyn J. Bond
W. T. Middlebrook Jr.
Preston R. Woodham

Small Hospital Forum

It's Hard to Keep House Without a Housekeeper

THE hospital of 40 beds or more needs a full-time housekeeper, in the opinion of those who should know best — small hospital administrators — a survey on this subject by The MODERN HOSPITAL revealed. When the hospital is smaller than 40 beds, administrators expressed some doubt that a full-time housekeeping job could be supported. Suggested combinations of functions favored housekeeping in tandem with maintenance; combinations with dietary and nursing functions were also mentioned. Few administrators believe a program in which several small hospitals in the same area would share the services of a single full-time housekeeper would be feasible, it turned out.

The survey covered 21 hospitals ranging from 29 to 160 beds in all parts of the country and all kinds of communities. Seven of the hospitals had full-time housekeepers. All but one of these were in the 60 bed class or larger; the one exception was a hospital of 35 beds with a full-time housekeeper who also performs some maintenance functions. In the remaining hospitals where housekeeping is combined with other duties, a number of different arrangements were reported, including combinations of housekeeping and maintenance, dietary or nursing duties, and in four hospitals there was a combination of housekeeping and administrative functions.

Most administrators think the housekeeping chores in a small hospital can be performed satisfactorily by an employe who has not had specific training or experience preparing her for her job — provided she gets along well with people and is capable of handling the employes in her department. Several administrators expressed the thought that a good housewife makes a good hospital housekeeper. "Our housekeeper kept a good home, raised two or three children and is now free to devote time to this job," one administrator wrote. "It is an ideal arrangement."

"My choice was a widowed mother of eight children," another administrator reported. "She has been quite successful in her capacity as housekeeper." Others favored specific experience in hotel housekeeping or restaurant work. Asked what background they considered most suitable in the person employed as housekeeper in the small hospital, most administrators mentioned specifically the ability to work with and handle people. "The housekeeper must be a discipli-

HOUSEKEEPING IN SMALL HOSPITALS

REGION	BEDS	FULL-TIME HOUSEKPR.	COMB. WITH OTHER DUTIES	BACKGROUND DESIRABLE	HKPNG. SHOULD COMBINE WITH: DIETARY	NURSING	MAINT'NCE	HOUSEKEEPER'S FUNCTIONS*	FULL-TIME HKPR. NEEDED AT (BEDS):	SHARED SERVICE
EAST	64	yes	sewing	general	yes	no	no	a b d e f i	25+	no
EAST	33	no	stores		no	no	yes	f h i	40+	
EAST	160	yes		personnel				a b d e f	100+	yes
EAST	61	yes		hotel	no	no	yes	a b d e f	60+	yes
EAST	47	no	nursing	nursing	no	yes	no		60+	no
EAST	56	yes		housewife	no	no	no	a b d e f i	25+	no
MIDWEST	30	no	supt.	personnel	no	no	yes		40+	no
MIDWEST	65	yes		housewife	no	yes	no	a f	40+	no
MIDWEST	80	no	nursing		no	yes	no	a d e f h i	40+	no
MIDWEST	66	yes		hotel	yes	no	no	a b d e f	40+	yes
MIDWEST	35	no	supt.		no	no	no			no
MIDWEST	50	no	laundry	housewife	no	no	yes	a d e f i	25+	no
SOUTH	40	no	bus. ofc.		no	no	no	a b c d e f h	40+	no
SOUTH	72	no	nurs. & maint.		no	yes	yes		60+	yes
SOUTH	60	no			no	no	yes		25+	no
SOUTH	29	no	nursing		yes	yes	no		40+	
SOUTH	55	no	supt.						100+	
WEST	90	no	maint.		yes	no	no		60+	no
WEST	35	yes			no	no	yes	a d e	25+	yes
CANADA	35	no		personnel	no	no	yes	a c d e f h i	25+	no
CANADA	34	no	dietary	diet. & purch.	yes	no	yes	a b d e f	60+	no

*(a) Supervision of maids.
(b) Supervision of housemen.
(c) Supervision of painting.
(d) Supervision of window washing.
(e) Supervision of wall washing.
(f) Supervision of linen room.
(g) Supervision of ward aids or attendants.
(h) Interior decorating.
(i) Laundry management.

narian and must command respect," was a typical observation. "She must be able to direct and plan the duties of her staff." The opinion of the group was summed up in one succinct answer to the background question: "common sense."

The most favored combination of housekeeping and other duties was the combination with maintenance operations. Nine administrators in the group thought this was a suitable combination of functions. Five stated that the logical combination was housekeeping and dietary duties, and four thought that housekeeping and nursing went best together.

Listing specific housekeeping responsibilities, the administrators named supervision of maids and supervision of the linen room most frequently among the housekeeper's duties. Each of these functions was named 12 times in the survey. Next, with 11 appearances, was supervision of wall washing. Then came window washing, supervision of housemen, management of the laundry, interior decorating and supervision of painting — in that order. In no case was supervision of ward aids or attendants considered a housekeeping function.

In hospitals where no one is specifically designated as housekeeper, these duties are divided among a wide variety of personnel. In one case, for example, the administrator has direct supervision over maids and housemen, operates the linen room and has charge of window and wall washing herself. A trustee who is chairman of the building and grounds committee looks after painting and major cleaning operations, and another trustee sees to the decorating. This hospital uses a commercial laundry. In another institution, the linen room and maids are under the nursing department, while the hospital engineer has charge of painting, wall and window washing, decorating and cleaning. In still another case, maids and housemen, along with the linen room, are considered nursing responsibilities, while the other listed duties are classified as maintenance functions.

The combination of housekeeping and dietary duties was considered suitable by five administrators, though this combination is in actual use in only one of these hospitals — a Canadian institution. "I find that a full-time housekeeper is not required in a small hospital," wrote the administrator of this 35 bed hospital. "The matron [compares roughly with the nursing director in U.S. hospitals] delegates certain duties to the cook in regard to the purchasing of supplies. The cook has supervision of the maids under instructions from the matron. Housekeeping duties are carried out by one of the maids under the supervision of the cook and matron. The matron issues orders in regard to cleaning, and so forth. We have found that this system works out very satisfactorily in our hospital. We also employ a janitor who works under the supervision of the matron. Window washing, wall washing, painting and decorating are done by the maids and janitor under the matron's supervision."

In one hospital, housekeeping is the part-time function of an employe who works in the business office, and in another it is handled in combination with storekeeping and purchasing.

Six of the administrators in this group believe that a full-time housekeeper should be employed in the hospital of 25 or more beds. Seven think a full-time housekeeper is not needed in institutions of less than 40 beds; five cannot see the hospital of less than 60 beds needing a full-time housekeeper, and two would go up to 100 beds before employing a housekeeper. Only five of the administrators would accept an arrangement under which several hospitals in the same area would share the services of a housekeeper. An outside housekeeper working part time in several small hospitals would not be satisfactory, in my opinion," a typical objection read, "because the administrator or other responsible executive in each hospital would have his own ideas of how each housekeeping function should be performed."

Another administrator objected to the scheme because he felt the person responsible for housekeeping functions should be available all the time in the hospital. Still another objected on the ground that personal service, the condition of patients' rooms and other things controlled by the housekeeper are the basis of desirable competition between small hospitals. "Division of help without a steady job does not give good results," was another comment. "There would be too much interference in management with different ideas and different ways and means of doing things," this administrator added. A few, however, did think the arrangement might work out if the hospitals were not too far apart.

VOLUNTEER ACTIVITIES

Dining Room for Diversion

Wesley Hospital, Wichita, Kan., has a double duty room. Recently the staff dining room, a large sunny room with windows on three sides, became a workshop for convalescing patients. Now this form of diversional therapy goes on five days a week, two sessions a day.

The Woman's Association has equipped the room for its second purpose, with sewing machine, jig-saw and electric range. The children's schoolroom gave up its loom, and the older children share its use with the adults. A croquet set, a shuffleboard and a typewriter will soon be provided. The long dining tables are pushed back against the walls and become reading tables.

Stork Club's Cover Charge

Kansas City's Stork Club is located at 4949 Rockhill Road. The cover charge is $1, and it has a possible clientele of 6000. Inside the door is a roster of names listed alphabetically, and visitors can readily check to see if their young friends appear on this social register.

The auxiliary of Menorah Hospital, Kansas City, Mo., runs the Stork Club, proceeds from which go to the maternity floor. Parents of the 6000 children that have been born in the hospital are invited to enroll their offspring on the club's register; the child also receives a small membership emblem.

The club is newly opened, yet it has recently presented its second incubator to the hospital. Grandparents are as interested as parents in the project, and many of them give generously.

One of the Stork Club's special services is a book of names. A surprising number of new parents have not found just the right name for their infant, having spent their full energies on finding a name for the wrong sex.

About People

Administrators


Whitelaw H. Hunt

Whitelaw H. Hunt has been named administrator of Cooper Hospital, Camden, N.J., where he had been acting administrator since December. He succeeds **Thomas E. Carden,** who has accepted a like position with Monticello Hospital, Monticello, N.Y.

Isabel Weber has been appointed associate administrator of Elizabeth Steel Magee Hospital, Pittsburgh, and will assume her duties there on September 1. Miss Weber recently completed a course in hospital administration at the University of Chicago. A graduate of Yale University School of Nursing, she has been employed in the nursing department of New Haven Hospital, New Haven, Conn., has been instructor and director of nursing at Cottage Hospital, Santa Barbara, Calif., and has been director of nurses at Oak Ridge Hospital, Oak Ridge, Tenn., where she also acted as administrative assistant.

Sister Mary Clare, R.S.M., has succeeded **Sister Mary Hildegarde** as administrator of Mercy Hospital-Street Memorial, Vicksburg, Miss. Sister Mary Hildegarde, who is now Mother Provincial, has her offices in Webster Groves, Mo.

Stephens A. Lott, administrative resident with the W. K. Kellogg Foundation, Battle Creek, Mich., and Bronson Methodist Hospital, Kalamazoo, Mich., has been appointed administrator of the new Blount Memorial Hospital, Maryville, Tenn. Mr. Lott received his master's degree in hospital administration from Northwestern University in June.

Fred Wetmore has resigned as superintendent of the Hunts Point Home for the Aged, an affiliate of the Hunts Point Hospital in New York City, to become associated with the executive staff of the Jewish Hospital of Brooklyn.

Sherwood Messner, a graduate of the class in hospital administration, Columbia University School of Public Health, 1948, has been appointed executive assistant of New York Hospital, New York City.

Frank G. Sheffler, who resigned as administrator of Union Hospital, Terre Haute, Ind., June 1, is the new administrator of Reid Memorial Hospital, Richmond, Ind. Mr. Sheffler served as president of the Indiana Hospital Association in 1943. **Frank R. Briggs,** formerly executive director of the Community Chest of Terre Haute, and prior to that director of public relations at Indiana State Teachers College, Terre Haute, has succeeded Mr. Sheffler at Union Hospital.


Anthony S. Dickens

Anthony S. Dickens has been appointed administrator of Alliance City Hospital, Alliance, Ohio. Mr. Dickens received his master's degree in hospital administration from Northwestern University this year. While attending the university, where he also received his B.S. degree in 1948, he worked at St. Luke's Hospital as an orderly and at the Highland Park Hospital, Highland Park, Ill., as assistant to the administrator.


Wade C. Johnson

Wade C. Johnson, a graduate of the course in hospital administration, Northwestern University, also a graduate of the Cornell Hotel School, has been appointed assistant to **Guy J. Clark,** executive secretary, Cleveland Hospital Council, Cleveland.

H. Carl Rowland has been appointed assistant superintendent to **James L. Rogers,** superintendent of Spartanburg General Hospital, Spartanburg, S.C. Mr. Rowland resigned as hospital administration consultant for the hospital division, South Carolina State Board of Health, to accept his new position. Previous to his employment by the state, Mr. Rowland was a field representative of the hospital and orphan section of the Duke Endowment, Charlotte, N.C.

Norman Bailey, administrator of Knickerbocker Hospital, New York City, has resigned that position to become assistant director of Michael Reese Hospital, Chicago. Mr. Bailey was formerly personnel director of Michael Reese, a position he left in May 1948.


DeForest T. Whipple

DeForest T. Whipple, postgraduate fellow in hospital administration, Strong Memorial Hospital, Rochester, N.Y., has been appointed administrator of Columbia Memorial Hospital, Hudson, N.Y., effective August 1. Mr. Whipple received his A.B. degree from Hamilton College in 1938 and his master's degree in hospital administration in 1947 from Columbia University School of Public Health.

Marjorie Hill McComb has been appointed director of Leominster Hospital, Leominster, Mass. She will succeed **Shannah N. Macfadden** who is retiring in August. Miss McComb has been assistant to **Conant Faxon,** director of Concord Hospital, Concord, N.H. Miss Macfadden has been with the hospital since 1921. She has been named consultant to the hospital by the board of trustees.

George H. Stone has been appointed assistant director of the Vancouver General Hospital, Vancouver, B.C. Mr. Stone is a graduate of the course in hospital administration at the University of Minnesota and served his administrative residency at Vancouver General. Mr. Stone was formerly assistant business manager of the Medical Group in Honolulu.

Dr. B. W. Mandelstam, superintendent of Nathan Littauer Hospital, Gloversville, N.Y., has been selected to head Mount Sinai Hospital, Minneapolis, which is now under construction.

Department Heads

Lydia Reich has been appointed director of nurses at Trumbull Memorial Hospital, Warren, Ohio. Previously, she

(*Continued on Page* 168.)

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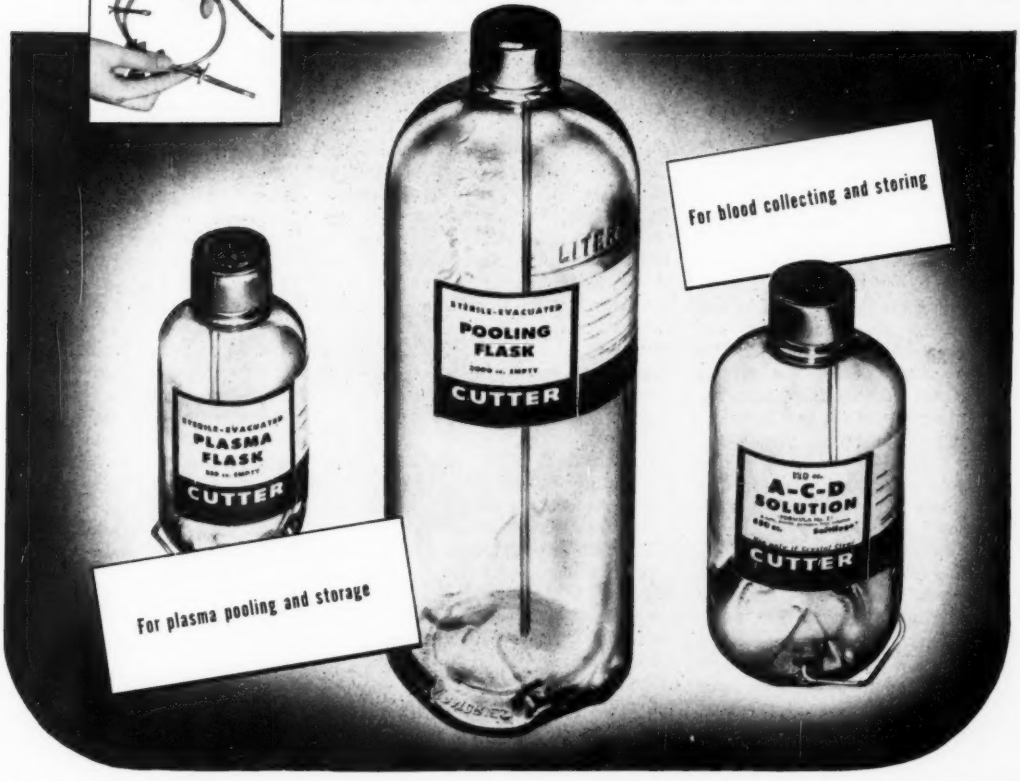

Volunteer Forum

Conducted by Raymond P. Sloan

EVERY MEDICAL STAFF IS A CLOSED STAFF

The difference between "open" and "closed" staffs is simply one of degree and where the line is drawn, which is a matter for the board of trustees to decide

LAWRENCE R. PAYNE
Director, Baylor University Hospital, Dallas, Tex.

NOWHERE in hospital literature, magazines or books can I find any authorities who advocate that a hospital must have an open staff or a closed staff. They always say that there are advantages and disadvantages to each, and that local conditions generally determine whether the staff should be open or closed.

Every medical staff is a closed staff already. The differences in opinion come when we begin to determine the degree to which our staffs should be closed. Is there an A.M.A. approved hospital today that admits any doctor to its staff who is not a graduate of an accredited medical school and a member of, or eligible to membership in, the local county medical society? I believe we will all concede that our staffs are closed below this point. Some of our staffs are closed at a higher level.

SOME ARE NOT ADMITTED

One may contend that a hospital operates an open staff and yet there are doctors of various types practicing the healing arts in one form or another in your communities whom you do not admit to your staff. Some of these men and women are even examined by the same state board of medical examiners that examines doctors with medical degrees. This is true in our state and I am sure it is true in several other states. Therefore, it would seem that our medical staffs are closed already to some degree. Now, the question arises, where are we going to draw the line? Also, is it going to be a permanent line or one that gradually rises to a higher level?

All of us will recognize the tremendous influence which our specialty boards are having today upon the practice of medicine in the United States. They had gained considerable influence prior to the war but during the war these specialty boards made a deep impression upon hospital medical staffs.

In our own hospital, when we found it necessary to reorganize our medical staff three and one-half years ago, a trustee raised the question as to whether our new plan was going to create a closed staff. One of our prominent doctors remarked that it would be closed only to malpractice and ignorance and would be opened to educational, enlightened and modern medical practices. The board of trustees came to the realization that it was responsible for the acts that went on in our hospital and that it must be the judge in the final analysis. Consequently, it faced the issue squarely and approved a plan whereby the trustees were to appoint the chiefs of the various services which we recognized in our hospital. These chiefs were to form a medical board after which they were to nominate the individual members in their services to this board. Following the medical board's approval the board of trustees was then to elect the staff. After the staff was elected in its four divisions, namely, consulting, attending, associate attending and junior attending, the last three divisions each named a representative to sit on the medical board with full vote and right to hold office.

For the first time in the 40 year history of our hospital, our board of trustees has vested some authority in the medical board to carry on certain professional work in our hospital. To the members of the staff go 90 per cent of our beds; to the members of the courtesy list (which makes up the balance of the county medical society) go 10 per cent of the beds.

HAS HEAVY RESPONSIBILITY

This medical board, which in our hospital includes 15 chiefs of services and three elected members from the staff, has a heavy responsibility upon its shoulders, including the work of building good technics in the hospital, raising standards in all the services, teaching the interns and residents, as well as the members of the medical staff themselves, and in general seeing to it, as a board, that each chief of service not only carries on the proper relationship with the men in his service, but also runs his service as the board of trustees has outlined. This type of arrangement has many advantages to the patient, the hospital, the doctors themselves, to say nothing of the board of trustees and the administrator. I believe that it is also incumbent upon this medical board to create opportunities for young, qualified doctors coming in to the community and to make certain that these young doctors are provided a place to work. If the medical board should refuse to recognize the young men the hospital would soon become static and would be in the hands of a clique.

I mention our procedure in order to show you that our medical staffs must be closed or carefully restricted

From a paper presented to the Arkansas Hospital Association, Little Rock, Ark., May 1949.

Conducted by Raymond P. Sloan

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From a paper presented to the Arkansas Hospital Association, Little Rock, Ark., May 1949.

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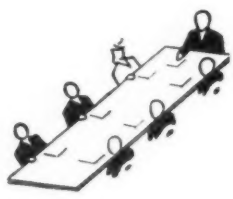
in order that we may protect our public. In the case of our own hospital our trustees had been evading this question for many years. They were afraid they would offend someone. They were afraid some good friend of the hospital would select a doctor who was not a member of our staff and, of course, they were afraid of a good many other things which they thought were hidden. When they fully realized the responsibility which they had, there was no difficulty in getting them to act.

Hospital trustees generally accept positions on the board feeling that they are going to add certain benefits to the hospital in a general way, but probably not realizing the great importance attached to their positions as trustees. Many of them never realize the responsibilities implied in a trusteeship. They do not realize it as individuals nor do they realize it as a body. Most new trustees coming on the board generally meet with the administrator and tell him of their anxiety to do whatever they can to help. Also, they will tell the administrator that they are counting on him to guide them in making decisions. This is the opportunity for which the administrator should be looking. He should sit down with those trustees and show them their responsibility. If a trustee once sees his true responsibilities he will take the right stand or else resign from the board. Our boards have been allowed to coast off into some sort of a feeling of security and the laws of our land have been very good to us in not jarring some of us out of this lethargy.

EVERYONE WANTS A CONTRACT

We are living in a day of contracts. Everybody seems to want a contract for anything he may do. Labor unions are demanding contracts for groups of employes working for management. Government is entering into contracts by the thousands through its various departments. It seems that too many men nowadays do not respect their own word unless they can be confronted with a signed agreement in writing. Everybody seems to want contracts except hospitals. It is true we employ our personnel and we have a definite understanding with it. We both agree to certain considerations and the employe goes to work. We make certain agreements with our patients. We promise to do certain things. We also make contracts or agreements with our vendors and the various supply houses, but many hospitals make no contracts or agreements with their doctors. A doctor can choose his hospital. That is to say, he can decide on the town in which he will practice and if it has a so-called "open staff" hospital, the hospital is at his mercy. Many hospitals do not choose their doctors. They take anybody who decides to move into town provided he can get into the county medical society. If the doctor has the right to choose the hospital, then the hospital should have the right to choose the doctor.

I must pay tribute to the American College of Surgeons, which is the first and the outstanding organization to help in raising standards in our hospitals. The college is under tremendous handicaps in its work because it is controlled somewhat by men who work in the hospitals and it may not be able to clamp down as tightly as some of us would expect it to. Boards of trustees should set standards for



hospitals as far above the minimum requirements as possible and then expect the administrators to maintain these standards. Individual members of many boards of trustees would be horrified if they knew of some of the medical practices that were carried on in some hospitals.

It would be hard to convince a trustee of a hospital that normal tissues were being removed in the hospital of which he was a trustee. As a matter of fact, it would be necessary to explain to many trustees what is meant by normal tissue. Most of them know in general what they want in their hospital, but they do not know how to put it into a policy. It is the administrator's job to keep hospital standards on a high plane. Also, it is the administrator's job to continue to raise these standards to the level which the trustees want. I wonder how many hospital administrators have taken a pathological report to their board of trustees when the pathologist continued to call their attention to the fact that a certain surgeon was removing normal tissues. If you have never done this, you really have something to look forward to with interest. I wonder, too, how many administrators personally keep up with the normal tissue reports sent in by the pathologist. How many have a pathologist at all taking care of the *entire work?* Too many hospitals still do not have routine pathological service, except, of course, when the surgeon wants to find out if there is a malignancy.

WORK OF TISSUE COMMITTEE

About three years ago, a tissue committee was formed in a hospital. This committee was appointed from the medical board and consisted of the chief of general surgery, the chief of obstetrics and gynecology, and the chief of pathology. These three men met and studied all the charts of every normal tissue reported by the pathology department. After reviewing each chart carefully, they put aside those in which they found justification for the removal of the normal tissue. Those cases for which they found no justification at all were reported to the medical board with recommendations as to what should be done.

In each case, the doctor involved was notified by letter from the medical board calling his attention to the fact that no justification could be found in the chart for the removal of this normal tissue. Most of the doctors called immediately upon the chief of the service in which they were working and obtained permission to insert additional sheets in the chart to justify their acts. One surgeon failed with three cases to justify them. On the second inspection he was found to have four cases. He was notified the second time, as were three other doctors, but he still failed to justify what he had done. The three other doctors, however, satisfied the chiefs of their services. On the third inspection this same doctor had four cases again and this time the tissue committee brought the report to the medical board which in turn refused to write him another letter, but called upon the board of trustees to prohibit him from further use of the hospital until he had signed a statement satisfactory to the medical board

WHEN THE DIET

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IRON	0.5 mg.	1.8 mg.
PHOSPHORUS	60 mg.	139 mg.
VITAMIN A	208 I.U.	444 I.U.
THIAMINE	0.05 mg.	0.17 mg.
RIBOFLAVIN	0.08 mg.	0.30 mg.
NIACIN	0.5 mg.	1.0 mg.
ASCORBIC ACID	3.1 mg.	4.4 mg.
VITAMIN D		62 I.U.
PROTEIN	2.9 Gm.	4.7 Gm.

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agreeing to certain conditions involving his medical practice in the hospital.

The board of trustees probably "sweat" more over this problem than it did over any other one which it had faced because the surgeon had a large practice and an economic problem reared its ugly head. However, the trustees came through and the surgeon was barred from the hospital for several weeks until he agreed in writing to all the conditions set forth by the medical board. The tissue committee has met only about three times since June 1946. There has been no further need for a meeting. I submit this because I believe it proves that a tissue committee is worth while.

How can we raise standards in our hospitals if we fail to recognize men who have prepared themselves for their specialty over those who have not? In our state a man can be graduated from medical college and, after passing his state board examination, can hang out his shingle and go into any number of hospitals and remove a brain tumor. To me this is a legal form of murder. Why can't we do something about it? We can if hospital trustees will realize their responsibilities. Our trustees can appreciate their responsibilities only if the administrators will call them to their attention in the proper way. A great deal of responsibility rests upon our shoulders. The Scripture says the sin of *omission* is as great as the sin of *commission*. If that is true then you and I are as guilty, if we fail to help raise standards, as the surgeon who attempts to operate on a patient when he is not qualified.

We are not trying to hurt any doctor; we are not trying to hurt any group of doctors; we are only trying to protect the patients who come to us feeling that they can trust us. Patients have a right to expect us to protect them and if we fail to carry out this responsibility to them we are just as guilty of negligence, which may be criminal negligence, as is the one who actually does violence to that patient.

A proprietary hospital owned and operated by a doctor or group of doctors must be handled differently from a voluntary nonprofit hospital which has a lay board of trustees. Although the problem is the same or similar to that found in the voluntary hospital, yet the management of the problem will vary. Even though a hospital is small and is operated by a physician or group of physicians, I believe that most of them are anxious to practice good medicine. Unfortunately, there are some exceptions to this fact in every state. Many small hospitals are proprietary, but the medical staff can be properly organized even on a small basis.

Most doctors who own and operate hospitals are more concerned about their ability to perform their duties as physicians than they are about the actual management of the hospital and will no doubt expect the administrator of their hospital to keep them up to date on the proper way to manage the staff organization. Often doctors are so busy with their practice that they have not realized how antiquated their medical staff organization may be and the responsibility for bringing this to their attention lies with the administrator.

WAYS TO PROTECT PATIENTS

To summarize, I suggest, first, that you study your medical staff by-laws in order that you can determine how high your standards are. Second, discuss these by-laws and their weaknesses with your board of trustees, and tell them that your hospital can never be any greater than the medical staff and the members who make up the staff. Third, tell them that only the trustees have the authority to raise standards, and it is their responsibility to determine how high these standards should go. Fourth, the trustees can cause adequate authority to be vested in its medical board, but it should be done only through appointments by the trustees and not by election from within the staff itself. Fifth, if the hospital is not large enough to have more than two chiefs, namely, medicine and surgery, the trustees should appoint these two chiefs. Sixth, follow through and see that these chiefs (whether two or 20) assume the responsibilities placed upon them by the board of trustees. Seventh, organize a tissue committee and give it authority to "call the shots." Eighth, review the purpose for which your hospital is being operated and determine whether it is being operated primarily (a) to make money, (b) for the benefit of the doctors, (c) for the benefit of the patients and the whole community. If you find that your hospital is being operated primarily for the benefit of your patients, then protect them with as high standards as you can possibly render.

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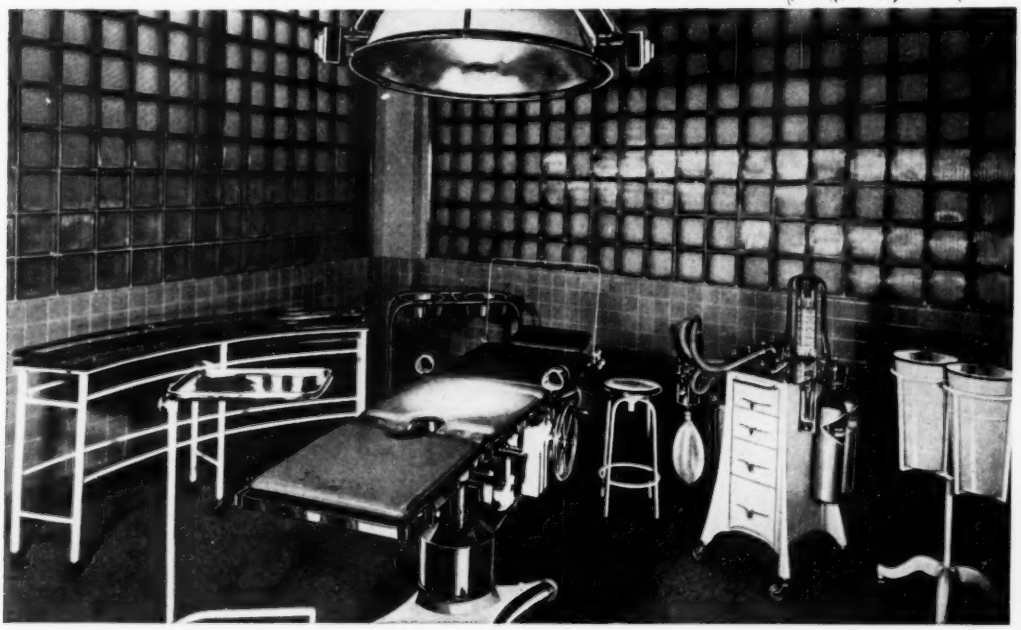

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HOSPITALS AND THE PRACTICE OF MEDICINE

ELMER HESS, M.D.
Erie, Pa.

IF WE expect to practice the best type of medicine in the best type of hospital surroundings, the association of the hospital and the medical profession must be one of mutual understanding and good will. It is our belief that this mutual understanding and good will must arise at the local level. The hospitals, of course, cannot hope to get along unless the medical profession sends patients to them for their medical diagnosis and treatment. Nor can many of the physicians get along very well unless they have competent, well managed, and well equipped hospitals to which they can send their patients for treatment.

SETTLED BY BOARD FIRST

It would seem, then, that any controversy arising between any member or members of the medical profession and any approved hospital would have to be settled first by the board of trustees and the staff of the hospital in the specific case brought before it. If there are disagreements between the board of trustees and the staff of the hospital, this situation should be thoroughly discussed and an attempt should be made to evaluate the facts by both sides so that there would be no injustice and no illegal practice in that particular situation. If the situation cannot be adjudicated to the satisfaction of the staff and the board of trustees or managers of the hospital, then an attempt should be made through the offices of the county medical society to see if something cannot be done to satisfy everyone in a given controversy. The decision should be within the Code of Ethics.

In Pennsylvania, we have just set up a new Committee on Hospital Cooperation, and we expect that this committee, formed as it has been of respected ethical men, will be glad to receive notices of controversies existing between hospitals and medical men. It will be more than glad to attempt to adjudicate them at the state level if the problem cannot be solved at the county level.

If, then, the situation appears to be hopeless, there is still another court of appeal. That court of appeal is the Judicial Council of the American Medical Association. However, since hospitals are not members of the association, the council would have no authority in hearing a case of a hospital group unless that group were controlled by members of the medical profession who are members of the American Medical Association. However, if in the mind of a member or members of the staff of a given hospital that hospital is acting in an unethical manner as a result of the decisions of the board of trustees, the aggrieved individual or individuals could call those members of the staff with whom they disagreed before the Judicial Council of the A.M.A. This could only be done by preferring charges of unethical conduct against one or more of the members of the staff of the given hospital.

On the other hand, if all efforts of adjudication had failed, the members of the staff of a given hospital could prefer charges against an individual for unethical conduct, and the matter could then be tried before the Judicial Council of the American Medical Association. A decision would then be rendered, and various actions could be taken at the national level, if such were considered proper, after all sides of the case had been heard.

Of course, the action by the Judicial Council would have no effect but a moral one upon the hospital management. If a case went that far in a given controversy, the only thing that could be done in a disciplinary way would be to refuse the hospital approval for intern training. If the outstanding members of the staff of that hospital were continued on duty after it was proved that they had been unethical and unfair according to the principles of medical ethics, a decision would have to be made by the Judicial Council after charges had been preferred against those men. If that hospital continued to retain on its staff an individual or individuals who were considered unethical by the majority of the members of the staff, they would also fall under the discipline of the Judicial Council.

DENIED A.M.A. PRIVILEGES

It must be remembered that action of this character would not be without great danger to American medicine as a whole. There are always two sides to a controversy, and the aggrieved medical man would immediately be denied the privileges of membership in the American Medical Association if he were convicted. He would then become an enemy of American Medicine, and this would, in all probability, be as bad a situation as could be imagined. Good public relations would be endangered by any such action on the part of the American Medical Association either against a hospital, against a staff, or against an individual.

Most medical men are unaware of the proper and true function of the American Medical Association in its relationship to individual physicians and to the approved hospitals of the country. It is difficult for me to believe that controversies between a physician or group of physicians and an approved, well equipped and well managed hospital cannot easily be settled. Unfortunately, when these controversies arise, many things are said which do not make for good personal relations beween the contending parties. If the physicians are not satisfied with the treatment they receive from hospitals, and vice versa, there is a perfectly normal way in which both sides can proceed in an attempt to correct the differences of opinion.

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It has been my experience that hospital managements often resent demands made upon them by members of the staff. Usually, the executive committee of the staff has a certain amount of advisory authority. However, most hospitals have a board of trustees or managers composed of the outstanding businessmen of a given community. Seldom does a physician sit with them. These men are concerned with the general setup of the hospital and, as a rule, are not particularly interested in the medical side of the picture. It is their job to employ an administrator who understands how to cooperate with the doctors; one who does not run the hospital too far into the red, and one who sees that his institution gives adequate service to the community in which the hospital is located.

CONDUCT PROFESSIONAL AFFAIRS

As a rule, the executive committee of the staff is composed of the heads of the various departments. These men conduct the professional affairs of the hospital and advise the board of managers on all matters that pertain to the best interests of the patients. Recommendations may or may not be accepted by the board of trustees. However, in some instances, the executive committee of the hospital staff, the board of trustees, and the hospital management have joint meetings at which both professional and economic sides of hospital management are thoroughly discussed and agreed upon in advance. These meetings may be concerned with the employment of technicians, medical men, and supervisors, and should develop suggestions that will provide the best possible public service.

It must be remembered that in the controversies which have arisen between the various professional groups and hospital managements that both parties were originally well satisfied with the professional and financial arrangements that had been made.

It is now necessary to be more specific concerning these subjects of controversy. Let me first take up the problem of the roentgenologist. During the past few years, there have been numerous resolutions concerning the unfairness of some hospitals attempting to practice medicine by exploiting specifically the radiologist, pathologist and the anesthesiologist. These three groups have perhaps been the most vocal in their opposition to the so-called practice of medicine by hospitals. However, there are many other groups employed by hospitals, either for salaries or on the commission basis or both. These include surgeons, internists and ear, nose and throat men. The only reason I have chosen for discussion the three specific groups is because they have been the most outspoken in their opposition to the control of their practices by hospital management.

Many argue that, for the most part, the roentgenologist seldom assumes full charge of the patient, but he does render valuable auxiliary services to the practitioner of medicine. As a rule, the only time he assumes complete charge of a given patient is when he is treating the patient for some malignant disease or some skin condition. However, his rôle in the treatment of a case is usually under the jurisdiction of the attending physician. Seldom does the patient seek the roentgenologist for medical care; he is usually referred for either diagnostic or therapeutic purposes. The patient remains under the supervision of the referring physician.

Of course, the roentgenologist is practicing medicine. He may maintain a private office and laboratory, separate and distinct from the hospital, where he does the private work which is referred to him and where his charges are based upon the ability of the patient to pay nominal fees. In his office, he uses his own judgment as to the charge for the professional service that is being rendered. However, even for his own private office, he still remains as an auxiliary to the referring physician even if he continues any treatment of the patient. Certainly, his opinion is worth while; certainly he practices medicine. If he has a downtown office, he has to purchase all of the expensive equipment as the need presents.

At the hospital, the equipment is usually provided, as are the office space and the necessary technical help. If he has a full-time position at the hospital, he signs a contract to serve as the full-time roentgenologist there and, as such, is an employe of the hospital. He may or may not be an active member of the staff. (I have never understood why he should not be an active voting member of the staff whether he is a full-time paid employe or not.)

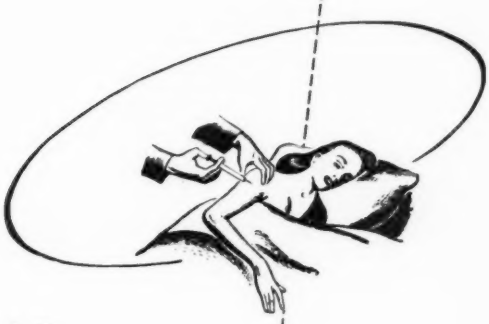
As a rule, the staff has little to do with the selection of a roentgenologist. In some hospitals, a man of reputation is selected by the management to do the roentgenological work on the recommendation of the executive committee of the staff. However, this is not a necessary procedure. Often the hospital will select a man and offer him a contract which, if it is accepted, obligates him to do all of the roentgenology of that hospital for the amount of money agreed upon between him and the hospital management. This distinctly makes him an employe of the hospital, but his work must be done to the satisfaction of the staff of the hospital. If this work is satisfactory to both staff and management, he usually has little difficulty in serving the best interests of the public that uses the hospital for medical service.

However, inasmuch as no other roentgenologist may come into the department and do the work, he has a monopoly because his patients are found for him by the other members of the staff. He serves in an auxiliary capacity to aid any member of the staff in either x-ray diagnosis or therapy. Here again, he is practicing medicine. The hospital is not. The roentgenologist has sold his services on a competitive basis to that institution for the advantages that would accrue from the association.

NOT LICENSED TO PRACTICE

The hospital, of course, is not licensed to practice medicine; therefore, it cannot practice medicine. The physician who accepts the position and who prefers to assume the contractual obligation with the hospital does so presumably because he is perfectly willing to do so and is perfectly happy to work under the conditions which the hospital specifies. He has to be a licensed physician. Therefore, anything he does is the practice of medicine. He may also work in a hospital on a salary plus a commission basis. He does all of the free work of the hospital for the salary which he obtains, and he does the private work of the hospital for regular set fees.

As a rule, he has no investment in the hospital equipment; therefore, for each dollar of the fee charged, the hospital should have a perfect *right* to cover itself from the standpoint of expense in running the department, maintenance of the equipment, replacement of the equipment, and all of the other necessary expenses which go with the maintenance of a competent, up-to-date roentgenological department. Hospitals should also have a certain percentage of that dollar to put aside for capital expenditures and for



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the replacement of equipment. This percentage should be an easy one to figure. The percentage proposition on which he and the hospital agree should cover both the items of expense and the cost of the necessary consultation work which he will do for the private patients of the members of the staff.

Where a roentgenologist has a contractual and commission relationship with a hospital confining all of his work to that institution, he already has something which is extremely valuable if based upon dollars and cents—and that is the absolute monopoly. He does not have to go out and work for a practice. He does not have to cultivate a practice. He has the practice handed to him. This has important financial value. Therefore, if a roentgenologist makes a contract with a hospital management to practice roentgenology, knowing that he has a monopoly, knowing that his patients will be found for him, knowing that all of the equipment and all of the expenses of the department are maintained by the hospital, and he signs that contract, he must do so because he wants to and because he believes it ethical.

However, if his services are not satisfactory or if a better man can be obtained for the institution, or if he does not meet all of the competitive elements that go to hold his job, then he must suffer the consequences. This is still free America; medicine is still a competitive field, and we wish to keep it that way.

It is no more wrong for a doctor to be the employe of a hospital than it is wrong for him to be employed by industry to take care of the workers on a straight salary basis or for him to be employed by the government. When a man is employed by industry, certainly he is an employe of the company; certainly the company is not practicing medicine, but the licensed physician is. There is no difference between the two people.

It has been argued by such brilliant men as Dr. W. Edward Chamberlain, Temple University Hospital, Philadelphia, and Dr. Eugene Pendergrass of the University of Pennsylvania and others that the only proper way for a roentgenologist to practice medicine is for him to rent from the hospital the floor space and the equipment, to employ his own help, and to render his own bills for all of the service rendered in the hospital. Men of this caliber, outstanding men in their profession, can make almost any demands in a competitive market and get them because they will be wanted and their demands will be met. However, the situations that exist in great medical schools like the University of Pennsylvania or Temple University are not at all comparable to the situation that may exist in a city of 100,000 people.

Conditions that prevail in a town of 20,000 with a small 30 bed hospital and those which prevail in the city of Pittsburgh, for instance, with a dozen first-class hospitals cannot be cited as comparisons. What we must do is solve the problem for the community in which the problem exists, according to the best interests not only of the profession and the hospitals in that community, but, more important, of the public in that community. It is believed that all these conditions can be accomplished and still be within the Code of Ethics of the American Medical Association. This is one reason it is almost impossible to have the same standards for practice in the whole country.

Fortunately, in the smaller hospitals, much of the routine work can be done by men who are not registered special-

ists. These men do splendid routine work and can avail themselves of the services of the metropolitan hospitals within a reasonable distance if and when they are needed. Few small hospitals are isolated. In this manner, the local people in small cities are almost as well taken care of as are the constituents of the larger community.

Many other medical men agreeing in principle with these statements argue that: (a) the roentgenologist's or radiologist's relation to the patient is no different from that of any other specialist, *i.e.* the patient theoretically always belongs to the general practitioner when he is referred to a specialist; (b) the roentgenologist is not always anxious to make the deal he does make with his hospital but does so because of social and economic factors already decided for him and which he does not feel able to ignore for the sake of independence; (c) when the hospital collects fees for medical services and returns part of them, it is generally agreed to be practicing medicine, and the physician involved is generally regarded as an employe of the hospital; (d) usually, the agreement between a hospital and a roentgenologist or pathologist, for that matter, is usually made *by* the roentgenologist (or pathologist); (e) there are varying economic factors in all arrangements which hold true in large, medium and small hospitals and between teaching and nonteaching hospitals; (f) it is necessary to have one man or one group in charge of the involved departments in hospitals that are otherwise considered as open; (g) that, in these cases, there is really no free choice of roentgenologist or pathologist. These conditions are necessary to ensure standard high class work for both staff and patients, it is argued. hospital managements are by-passing the general practitioners in many cases and giving care in these departments to patients who have not been directly referred to these hospital departments, *i.e.* practicing medicine.

So go the various arguments from the managements of hospitals and the roentgenologists. Speaking unofficially and only for myself, may I make the following observations? I can fully appreciate the position of the roentgenologist who would like to have a Utopia and who would like to feel that he is practicing medicine just as independently as is the surgeon or the internist. However, I still feel that it must be recognized that the services of the roentgenologist are highly specialized and that they are necessary not so much for the complete management of the patient who is sick, but as an adjunct to the diagnosis and treatment of the ill person.

Now let us look for a moment at the pathologist. This, again, is only my opinion. Of course, the pathologist has to be a doctor. He has to be a licensed practitioner of medicine. No pathologist can legally head up a department of pathology in any of the hospitals in Pennsylvania unless he is licensed. The pathologist, however, does not practice medicine in the truest sense of the word. He again is an adjunct to the professional man in charge of any given case. His services are necessary in many instances for the proper clinical management of a sick person. His laboratory supplies confirmatory evidence of a diagnosis and is frequently used during the treatment of a disease to judge the improvement of the patient in the course of that disease.

The actual pathological work of the laboratory consists of the diagnostic tissue work from the specimens that are removed by the surgeon in the op-

erating room, in performing the necropsies, and examining the conditions of the body so that a diagnosis may be confirmed or made as to the cause or causes of the death. Here, the pathologist is a most valuable partner of the practicing physician. However, unless the pathologist is called in as a clinical consultant, he seldom, if ever, sees a patient from the clinical point of view. Many pathologists are good clinicians. Many practicing physicians use the pathologist as a consultant, and they should. When a pathologist is called in as a consultant in a given case, then he should charge a consultation fee for that service. That fee should be definitely his, and the hospital should have no part of it. It would be impossible for a pathologist as a rule to set up a private laboratory and build his own practice because there would be little call for his services from the general public unless it was referred to him for certain things. Those specific things would be laboratory tests to assist the physician in the management of the case.

Therefore, while being a pathologist is practicing medicine, it is, again, an extremely specialized part of the practice of medicine and seldom does the pathologist assume charge of the diagnostic or clinical management of the sick individual. Again, pathologists, for the most part, are employed by hospitals for the simple reason that hospitals cannot take care of the patients of the referring doctors without the services of a competent laboratory.

Much of the work of the laboratory today is chemical as well as strictly pathological, and a great deal of private work is referred to the laboratory of the hospital by outside men who seek the help which only the laboratory can give them in the management of many of their cases away from the hospital. Here, again, the hospital usually has a contract with the pathologist so that this private work outside of the hospital is done on a commission basis. The pathologist retains a certain portion of the fee which pays him for his consultative effort, and the hospital retains a certain portion of the fee which should constitute its share of the dollar spent for overhead expenses if the latter assumes these expenses. Again, these arrangements are usually made on a contractual basis because, in most instances, the pathologist would be unable to earn a living if he had a private pathological laboratory not associated with a hospital.

As a rule, the hospital seeks a pathologist of ability. Just as in every other walk of life, there are some men who are better qualified than others. Institutions, naturally in a competitive field, bid for the services of the man they want. If the arrangements are mutually satisfactory, the hospital and the pathologist sign a contract and the partnership takes place. If, in the opinion of any individual pathologist, he is being exploited by the hospital and is not receiving fair treatment, there should be some way in which both sides might compromise their differences.

A pathologist may not prove to be satisfactory to the staff of the hospital. The staff members, then, should have a perfect right to inform both the pathologist and the management that they are dissatisfied with the services of the pathologist and he should be informed as to why his services are not satisfactory. If they do not measure up to the demands of the staff and the hospital management, that man should be discharged the same as any other employe, and an attempt should be made to get

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1. Brewster, J. M., U. S. Naval Med. Bull. **49**: 1-11, January-February 1949.

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another more suitable man to take his place. Again, this is a competitive field, and the man who satisfies both the staff and the hospital management should not be in jeopardy of losing his position.

On the other hand, if any one of the three concerned becomes dissatisfied, there should be an opportunity available at the local level for the party or parties interested to adjudicate their differences. If it cannot be done at the local level, then an attempt should be made at a higher level. In the state of Pennsylvania, again, a hospital is not approved for intern training by the State Board of Medical Education and Licensure unless it has a qualified full-time pathologist. This would seem to me to be the answer to many of the arguments which have been put forth to the effect that the hospital is again practicing medicine.

The hospital is not practicing medicine. The hospital is furnishing a qualified practitioner of medicine who is a specialist in pathology to serve the staff of the hospital for the best interests of the public and for the preservation of the health of the community.

Concerning anesthesiology, only recently has the House of Delegates of the American Medical Association officially gone on record that the practice of anesthesiology is the practice of medicine. Of course the practice of anesthesiology *is* the practice of medicine. Unfortunately, in the early days, the surgeon in the operating room was in sole charge of the patient, and in the early days, when ether was the only anesthetic, the surgeon assumed full charge for the individual who gave the anesthetic to the patient.

This practice brought into being the nurse-anesthesiologist. The nurse-anesthesiologist still exists in many communities today. There are many small hospitals in which there is not enough work to demand a full-time professional physician anesthesiologist. In these small hospitals, excellent anesthesia is conducted under the supervision of the operating surgeon by nurses and interns. In such cases, there is nothing illegal about the nurse giving the anesthetic. It is being done under the supervision of the surgeon in charge. It cannot be said that the nurse is practicing medicine. I do not think she is. I think that the surgeon is practicing the medicine, and if he has employed a registered nurse who has been trained to conduct anesthesia under his supervision, that is perfectly all right. She is doing the job under the direct observation and guidance of the surgeon doing the operation.

Many of us, myself for instance, have always felt that anesthesia belonged in the province of the physician, and it has always bothered me that more medical men have not trained themselves to give any and all kinds of anesthetics and that they have not limited themselves to the specialty of anesthesia. However, as the years have rolled by, more and more men are doing it.

The anesthetist is, in my opinion, one of the most important assistants that the surgeon has. Ideally, he should examine the patient before the anesthetic is given. He should select, in consultation with the surgeon, the type of anesthetic most suitable for the patient and for the type of operation that is to be performed. He should give the anesthetic, he should then supervise the postoperative recovery of the patient for several days, administering the necessary fluids, doing the necessary after-care so important to the postoperative convalescence of the patient. This, in my opinion, is purely a medical job and divides a little bit of the grave responsibility that exists in every operative case. It certainly would be of great assistance to the surgeon and is the ideal way for anesthesia to be conducted.

I could go on in the same train of thought covering all forms of medical practice within the clinic and hospital groups. Arguments, both pro and con, could be presented that would take a Solomon to decide.

CODE OF ETHICS GOVERNS

What the future rulings in all of these questions will be is beyond my comprehension, but it must be remembered now that the governing factor is Section 5 of the Code of Ethics of the American Medical Association: "It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy."

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Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

Ubiquity and Rationale of the Treatment of Pain

THE practitioner tends to use potent pain killing drugs when a specific pharmacological antagonist would be more physiological and would frequently correct the disordered function which is the cause of the pain. For this reason we have prepared the following table of painful states and have indicated after each the treatment of choice. In most instances one will note that the potent analgesics are frequently not the best treatment and are used only as a last resort. In certain instances of acute pain as in burns or terminal cancer the potent but potentially addicting drugs should be used freely in adequate amounts to provide comfort.

Judging from the variety of clinical treatments, most pain is antagonized by physiological antagonists which change the altered physiology toward normal. Thus, as an example, drugs used in the treatment of headache have no discernible analgesic effect. —C. C. PFEIFFER, M.D.

PAINFUL STATES	SPECIFIC RECOMMENDED STATES
Abscess, acute Boils, etc.	Incision and drainage. Penicillin, sulfonamides, moist heat.
Angina Pectoris	Glycerol trinitrate, amyl nitrite.
Biliary Colic	Nitroglycerin, amyl nitrite, aminophylline, dilaudid.
Burns, severe	Pressure bandage, dilaudid, morphine, methadone, intravenous procaine.
Cancer Cells, invading	Testosterone, stilbesterol, specific cellular antimetabolites such as nitrogen mustard. The analgesics: methadone, metopon, morphine.
Causalgia	Sympathetic block or trigger-point block with procaine; procaine, tetra ethyl ammonium chloride intravenously, continuous tetracaine spinal anesthesia.
Central (thalamic) pain	No effective treatment (methadone?). Frontal lobotomy?
Claudication	Rest, sympathectomy, physical therapy. Tetra ethyl ammonium.
Glaucoma	Physostigmine, pilocarpine, di-isopropyl fluorphosphate, operative relief of tension.
Dysmenorrhea	Atropine, ephedrine, amphetamine, pavatrine, trasentin, antihistamine drugs, acetylsalicylic acid, acetophenetidin, codeine, phenobarbital.
Gout	Acetylsalicylic acid, cinchophen, colchicum.
Headache	Acetylsalicylic acid, acetophenetidin, ergotamine tartrate, oxygen therapy (+5% CO_2), sodium nicotinate, antihistamine drugs, codeine.
Heat Cramps	Salt tablets.
Hematoma under fingernail	Trephine nail with sharp point of scalpel or penknife.
Hemorrhoidal pain	Hot baths, topical anesthetics, sclerosing solutions, surgery.
Itch	Antihistamine drugs, menthol-phenol paste, calamine lotion, intravenous procaine.
Myalgia	Procaine block, counter-irritants, physical therapy, curare in oil, oral "Myanesin," oral "Tolserol."
Night cramps of voluntary muscle	Quinine 0.3 Gm. at bedtime, calcium lactate 1.0 Gm. T.I.D.
Obstetrical pain	Heroin, meperidine, nitrous oxide, (paraldehyde, scopolamine, or barbiturates will produce amnesia).
Otitis Media	Phenol locally, penicillin, sulfonamides.
Paraplegic pain	Antero-lateral cordotomy.
Peptic Ulcer	"Dibutoline," atropine, antacids.
Phlebitis	Physical therapy, sympathetic block.
Pleurisy	Partial pneumothorax, codeine to control cough.
Post-herpetic pain	Pituitary extract, physical and radiation therapy, procaine or alcohol block.
Postoperative gas pains	Duodenal and rectal tubes, neostigmine, pituitary extract.
Psychogenic pain	Phenobarbital, psychotherapy, "Tolserol," "Myanesin."
Renal Colic	Meperidine, nitroglycerine, aminophylline, dilaudid.
Rheumatism	Salicylates, acetylsalicylic acid, acetophenetidin.
Rheumatic Fever Rheumatoid Arthritis	Compound E (Cortisone), Adrenocorticotrophic hormone.
Sprain of joint	Infiltrate with 2 per cent procaine HCl (without epinephrin), physical support.
Spastic Colitis	Atropine, bland diet, sedatives.
Trigeminal Neuralgia	Trichlorethylene, procaine and alcohol blocks.

The relation of the NUTRITION CLINIC to the community

MARJORIE H. EDWARDS
Clinic Nutritionist, Mountainside Hospital, Montclair, N.J.

IN ORDER to illustrate how the nutrition clinic fits into community affairs, it would be advisable to give some background, as far as the organization is concerned. The nutrition clinic at Mountainside Hospital, Montclair, N.J., prior to 1946, was staffed by the nutritionist of the local chapter of the American Red Cross, who spent three mornings each week seeing patients referred from the various clinics by appointment only. She attended the diabetic clinic once weekly and the prenatal clinic twice weekly for the purpose of instructing patients. On April 1, 1946, the hospital dietary department employed a nutritionist for the clinic and provided an office for her near the clinic entrance and easily accessible to patients. The nutritionist also instructs student nurses in the school of nursing.

TRIED DIFFERENT APPROACHES

Because a definite program had not been established, there was an opportunity to try different approaches to nutrition education. In addition to the routine visits of patients for diet instruction, the nutritionist began attending most of the clinics. This was done to familiarize the doctor with her work and to obtain better follow-up work with the patient, both by eliminating extra steps and by saving time for the patient. By her attendance at the clinics, the nutritionist has a better opportunity to consult with the physician about the patient's condition while the case is still fresh in everyone's mind and the patient is present. Often the patient feels that a special visit to see the nutritionist is wholly unnecessary and, as a result, too many appointments are not kept. Obviously, in such instances there is little hope for success so far as the nutritionist's work is concerned. Often the doctors are interested in up-to-date methods of diet therapy and would like to apply these but they need someone to interpret to them what is meant by such diets in terms of food. Also frequently they lose track of the time a patient has been on a diet and it is here that the nutritionist can make suggestions to relieve the patient from his monotonous diet. By being a member of the dietary department staff, the nutritionist can obtain better follow-up on patients referred to the clinic after a hospital stay. The diets used under such circumstances can also be more uniform and in accordance with those used throughout the hospital.

Work in the community was begun when the nutritionist also became a member of the staff of the Council of Social Agencies. Thus valuable contacts were possible with social workers in the community who were associated with the nutritionist in clinic work. At monthly meetings, nutrition problems of the community are discussed and the nutritionist has an opportunity to outline desirable goals toward which the community should strive. The Red Cross nutritionist also attends these meetings which afford opportunity for joint efforts concerning nutrition education in the community.

Cooperation with the nutrition committee of the Red Cross was the next community venture of the hospital's clinic nutritionist. This committee consists of professional nutritionists and lay persons who are interested in nutrition. At sessions of this committee ideas are presented which are designed to spread nutrition education and to better the nutritional level of the community. Any problems that arise, such as budgets and food shortages, are discussed. People are shown the necessity for fostering good nutrition for good health and the hospital shares in this community problem through its nutritionist. Thus the hospital is drawn more closely to the attention of the townspeople and they become aware of the many services it has to offer the community.

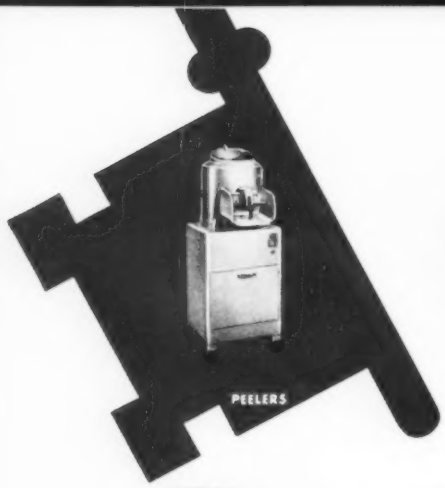
MAKES HOME VISITS

The clinic nutritionist occasionally makes home visits to see patients, which is an advantage in obtaining a clear history and also in providing an incentive for the patient. If a patient is unable to make a visit to the clinic for diet instruction, the nutritionist can bring it to him and often make him more aware of the need for adherence to the diet. Such attentions increase the confidence of the patient in the hospital and what it is doing for him. By means of home visits, it may be found that the patient does not have the proper facilities to permit him to maintain his diet. Situations like this are not always uncovered through the diet history, for the patient does not always reveal his true state of finances and pride keeps him from telling of his lack of certain equipment. Sometimes it is found that patients may be using the wrong utensils for measuring food, thereby throwing their diet out of balance. Often it is possible to see the patient's family and make it more aware of the need for the diet and treatment, thus making it easier for the patient to follow his diet. Ill-informed but well mean-

Contentment

To watch the sun-ripened berries as they simmer, in small batches, into rich, fruity preserves, is a memory-stirring experience. Grandmother's magic reaches its highest art in our Sunshine Kitchens . . blending the ripe fruit, with crystal cane sugar, according to time-tested recipes to give you Sexton preserves, jams, jellies, and marmalades. Your guest will know the difference.

Good Food for *Pleased Guests*



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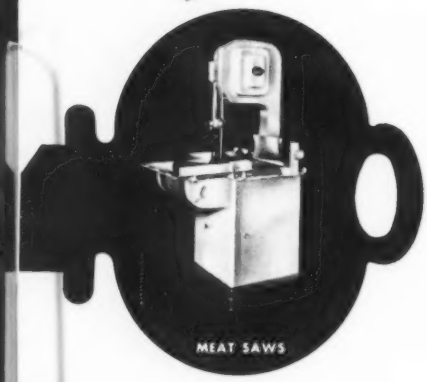
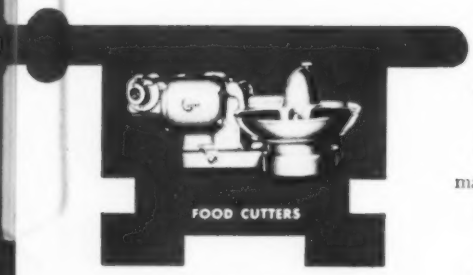
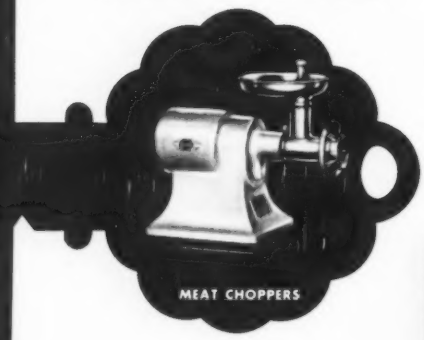
Kitchen machines to improve standards and lower operating costs! Food machines to enhance flavor and quality, to cut costs through increased employe-volume and decreased waste! Every one of them Hobart through and through — dependable, sturdy, long-wearing — clean in design and clean in performance. All of them are backed by the greatest name in food machines—designed and produced in a complete range of sizes and capacities—sold and serviced through nation-wide representation.

That's what an all-Hobart installation means to your operation! See Hobart food and kitchen machines — select the individual models that meet every need most economically. You'll find that the Hobart trade mark unlocks new portals to performance. Quick deliveries, too!







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TRADE MARK OF QUALITY

Hobart FOOD MACHINES

THE HOBART MFG. COMPANY, TROY, OHIO • Factories in Troy, Dayton, Greenville, Minneapolis, U. S. A. • *The World's Largest Manufacturer of Food and Kitchen Machines*

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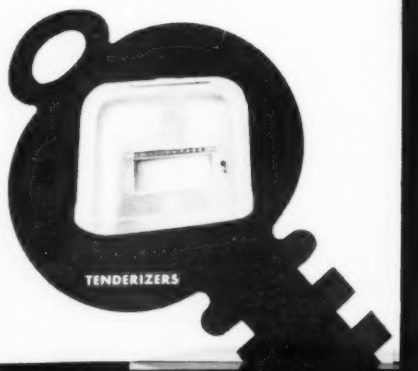
Steakmaker tenderizers are manufactured by Hobart-Federal Engineering Corporation, a Hobart Subsidiary.



ing relatives will often prod the obese patient into eating "just a small piece of cake" and the nutritionist has to chalk up another failure. A little explanation of the "whys and wherefores" of the diet will help the family to understand the importance of a diet and the need for it to help in every way it can.

A new program recently organized is "Mothers' Classes." These are held in the three towns nearest the hospital. A series of eight lectures is given on various topics of interest to mothers-to-be. The hospital nutritionist attends in one town to give two and one-half hour classes on nutrition in normal conditions and nutrition in pregnancy. Through this association with the hospital, the mothers become aware of its services and learn that the hospital is not an impersonal organization. In these classes, good food habits are taught not only for the mother, but for the entire family. Literature is passed around in the classes for the patients to take home with them. An entire family is thus exposed to good nutrition through the medium of one of its members. Other instructors in the courses are given copies of the outlines for both of these lectures in order to correlate the diet material with their lectures. It is a progressive program as far as the nutrition is concerned since it observes the premise that preventive medicine should be part of the hospital's program. We feel that it will have lasting effect in view of the interest of the group and that by such means it is possible to impress good food habits on people early in their family life.

There is another excellent opportunity for education in the school dental health project which is conducted in the outpatient department. Children are brought from the school in groups of about four or five. While one child is being seen by the dentist the others wait in the reception hall. A volunteer is in charge of watching them and keeping them occupied. The volunteers met with the clinic nutritionist at the beginning of the school year and a program of nutrition education for the children was reviewed with them. Nutrition posters and booklets were made available to the children along with cut out books and pictures to color. All these items deal with nutrition and serve the purpose of educating the children and also keep them occupied. Occasionally the nutritionist visits the group to talk with the volunteers and check their progress and to talk with the children regarding their dietary habits. This sort of education is beneficial for the entire family. The child usually takes home some of the material and talks about what he has learned at the dentist's office. The children often are a means of directing parents toward better nutrition by their interest in eating the right foods. They are usually eager to tell the nutritionist on their next visit that they have eaten an ideal breakfast or have had the proper foods. Recently the children have been asked to keep a record of the foods they are to eat in the following week and return this record to the clinic on their next visit. This method, of course, is not expected to be accurate—the children may lose the records, families may put down what they should have had instead of what they do have—but, in spite of these drawbacks, it is felt that the procedure will stimulate the children and their families toward better nutrition habits.

In the near future, it is hoped that more diabetic classes may be formed. The classes would be for both outpatients and hospital patients, private as well as clinic. Up to the present, it was thought that the demand for such classes was too small to start such a venture. Individual instruction was given and seemed to fill the need. However, it appears that more people would be interested in such classes which would be given in the hospital with the clinic nutritionist providing the diet instruction.

CLOSE COOPERATION NEEDED

Our experience clearly indicates the need for close cooperation between the dietary department and the social service department of the hospital and the community. The ever present financial problem which so often confronts the clinic nutritionist can be solved much easier with the assistance and cooperation of the social worker. The diet history becomes much clearer in the light of the information uncovered by the social worker through her contacts with the patient. The success of the diet often hinges upon due understanding of the patient's social background and degree of adjustment to society. The social worker has this information which enables the nutritionist to adjust the diet to the patient's situation.

It has been possible to accomplish all of these activities, even though this is a hospital of 375 beds, because the nutrition clinic is comparatively new and there are not as many direct referrals as there are in older nutrition clinics. It is felt that community activities such as the foregoing do a great deal toward keeping people informed concerning the services which are available and materially aid the hospital's public relations program.

HOW TO REDUCE FOOD COSTS

JOHN W. STOKES

Management Consultant, Boston

TO REDUCE food costs, in these inflationary days, is a problem for all who are concerned with public feeding. For the hospital it is even more difficult because of the importance of the food service to the institution.

Food in the hospital is not only a means of sustenance. It is also a therapeutic agent. Furthermore, good food plays an important rôle in building patient and employe morale. Savings that are effected in food costs, therefore, must not be made at the expense of good, over-all dietary service.

The rapid rise in food prices has made hospital boards and executives painfully aware of the necessity for better food management. The inflationary spiral made it imperative that food waste and inefficiency be eliminated. In this sense, inflation has not been an unmixed evil.

In applying scientific management principles to dietary operations, we find that there are many factors affecting food costs. Let us look at some of these.

PURCHASING

A sound food purchasing policy for any institution is what is known as "specification buying." This means to determine through tests the types, grades and sizes of each food item that are best suited to the use of your particular hospital and to see that you get them.

In food buying, the cheapest is not necessarily the most economical. "Yield" is an important criterion. For example, a "low commercial" grade of beef may cost less per pound but will contain more bone, fat and gristle than a "top commercial" grade. The higher priced beef when cooked will yield more servings to the pound and hence the cost per serving is less. Again, tests will show whether the "drained weight" of a No. 10 can of vegetables of one brand is greater or less than that of another No. 10 can bearing a different label.

Sizes and types of containers are important. To illustrate—in a Massachusetts hospital we found 600 half-pints of milk being purchased daily in paper containers. By changing to glass, we were able to save just one cent per bottle, or more than $2000 per year.

Good purchasing involves frequent visits to the market, where one is available, as in the larger cities. It means checking prices with more than one purveyor on such daily items as fresh meat and vegetables. It presupposes staff cooperation and a flexible menu so that "good buys" can be taken advantage of when they are available.

RECEIVING AND STORAGE

It is amazing how little attention is paid in some hospitals to the checking of food and supply items when they are received. In a Florida hospital, cracked ice was received in bags supposed to contain 100 pounds each, but on checking some weighed only 70 or 80 pounds, yet the hospital was paying for full weight.

Fresh tomatoes are often purchased in lugs usually weighing 32 pounds. Some dealers make a practice of repacking the tomatoes loosely so that the net weight of the lug may be only 27 or 28 pounds.

Every food and supply item coming into the hospital should be weighed or counted at the delivery entrance and properly recorded on a receiving slip. Such slips should be made out in duplicate, with one copy going to the accounting office. If any discrepancy is found or if quality is not up to standard, the purveyor should be notified immediately and an adjustment should be made.

Foods should be placed in proper storage immediately upon receipt. The need for this in the case of perishable items is obvious. Yet in a Pennsylvania hospital recently we saw dozens of quart bottles of milk standing in the delivery entrance for nearly two hours before being placed under refrigeration.

In another hospital, we found lettuce and other perishable vegetables allowed to remain out of storage over night until the chef came in early in the morning to inspect them.

Refrigeration facilities should be adequate and refrigerators should be inspected daily for temperature and good housekeeping.

Storage rooms should be rodent-proof, dry and at proper temperatures, with food kept off the floor on well constructed racks.

Proper storage and refrigeration are important from the standpoint of sanitation and also to prevent waste. Even under optimum conditions, a certain amount of shrinkage will take place. Excessive shrinkage increases food cost.

Storerooms should be kept locked and food should be issued only on duly authorized requisitions. Otherwise, pilferage may cause food costs to mount.

PREPARATION AND COOKING

Considerable food waste may occur in preparation. Most hospitals, for example, have mechanical potato peelers. These machines are sometimes operated by kitchen workers of low intelligence. We have seen potatoes left in the peeler while the attendant stepped out for a smoke, not to be taken out until they were reduced to the size of ping-pong balls. An automatic warning device or one that shuts off the machine after a proper interval will prevent such waste.

Here many hospitals are penny-wise and pound-foolish. Poorly paid, incompetent kitchen help can waste expensive food. A good chef with experienced helpers can save many times

From a paper presented at the New Jersey State Hospital Association meeting, 1948.

the additional salary paid him. The food he turns out will also be far superior in taste and appearance.

The art of quantity cooking is a large subject in itself and cannot be discussed in detail here. However, it is well known that over-cooking of meats at high temperatures causes excessive shrinkage. This is a source of waste that can be controlled.

Also wasteful are the rule-of-thumb "recipes" in which some cooks indulge. In a hospital kitchen not so long ago, I saw two 14 quart pots of canned corn being heated on the stove. On top of each pot was a 1 pound print of butter, which cost the hospital at that time 93 cents. Good institutional practice would call for not more than a quarter pound of butter for each pot and the butter should not have been added until the vegetable was about ready to serve.

The answer is that a written formula should be prepared for each dish and the cook should be required to follow the formulas implicitly.

Seasonings should not be left to the whim of the cook. One of the finest restaurants in Dallas, Tex., which I visited last year, makes up a box for each batch to be cooked, containing all of the small ingredients and seasonings. These are prepared the day before and are sent down to the kitchen from the storeroom at the beginning of the day with the formulas.

In one hospital recently we watched the preparation of the midnight meal. The kitchen woman in charge had no idea how much coffee to use. She simply threw in a 1 pound can of coffee although there was only a gallon of water in the urn. Actually at least 2 gallons of water should be used with a pound of coffee.

Upon investigation, we found a lack of uniformity in coffee making for the other meals. By establishing standard formulas for coffee making in this hospital, we were able to save on coffee costs at the rate of $1620 per annum.

Ordering is important. In one hospital we found that the cook was making up practically the same quantities from day today although the house count of patients and employes varied greatly. Over the week end, when many of the student nurses were away, the total count dropped. Result —much good food going into the garbage.

A good way to check any restaurant, by the way, is to weigh and examine the garbage barrels daily. A comparison of day to day garbage volume may be most enlightening.

FOOD PORTIONS

Many institutions carefully plan their dietary operations so that the food cost will come close to a predetermined figure. When such plans fail of their purpose it is often due to lack of uniformity in portioning.

A few months ago we watched a nurse dishing out plates in a diet kitchen, heaping on an extra scoop or two of potatoes here and extra slices of bread and pats of butter there. We examined the 14 trays from that ward when returned to the dishroom. We found leftover food on every tray. On five trays no butter had been used. On seven others only half the butter had been taken. On practically every tray at least one slice of bread was returned.

By arranging to serve only one slice of bread on a plate unless more was requested, we were able to save considerable bread each day.

The butter at that hospital was made into pats by a machine adjusted to cut 48 pats to the pound. By changing the adjustment, this was increased to 72 to the pound. (This is a generous portion when you realize that many good restaurants have been forced to cut 108 or 144 to the pound.)

We also noticed that in the employes', nurses' and staff dining rooms —although cafeteria service was used —butter was placed in bowls on the tables, sometimes as many as two pats to a person. We placed the butter in paper chips on a tray on the cafeteria counter and allowed each one to take what he wanted. This cut the consumption of butter almost in half. As a result of the adjustment of the machine and the change in the employes' dining rooms, the actual saving in butter costs in this hospital, figured at the 89 cents per pound it was then paying, will total more than $3000.

I realize that there is bound to be a certain amount of food rejected by patients owing to their physical and mental condition. I also know that there are some patients who require heavier meals than others, such as the mine workers we saw early this year in a "compensation ward" in a hospital in a Pennsylvania coal mining town. However, through proper cooperation of the dietary and nursing staffs and the right kind of supervision, adequate uniform portions can generally be maintained and waste from this source can be minimized.

SPECIAL DIETS

It has been our experience generally that such special diets as cardiac, ulcer and diabetic seem to constitute about 10 per cent of the total patient load. In some hospitals, we have run into an abnormally large number of unusual special diets not included in these three categories. In these hospitals, one or more doctors are prescribing special diets for almost every one of their patients. In one instance where food service had been poor, we wondered if these special diets had not been prescribed so that these patients might get more nearly adequate food.

We have no quarrel with special diets. The point we make is that they usually cost more than the regular diet from a raw food as well as a labor standpoint. In one hospital, we found that special diets averaged close to 40 per cent more than regular diets in raw food cost. This added cost should be frankly recognized.

EMPLOYES' MEALS

Good food plays an important part in employe morale. Employes' meals should be adequate. Portions should be uniform. Care should be taken to see that favoritism is not allowed to creep in.

Experience has generally shown that the paid cafeteria plan is superior to free meals for employes. Although it involves paying higher wages, it is both good business and good employe relations practice to allow each one to choose what he wants and pay for it.

FOOD COST CONTROL

There are many systems of food cost control some of which are quite elaborate. Our experience has been that the best system is one that is designed to meet the particular needs of the given hospital. There are certain essentials, such as the check on goods received, controls of inventories and records of issues from storerooms and kitchens. The best system, however, is the one that is the simplest and the least costly to operate.

In this connection, it is important that an accurate daily count of meals served be taken. We have often found the estimated figures for meals served to be from 15 per cent to 20 per cent

(*Continued on Page* 132.)

38 Million Times a Month

CARNATION SAYS:

"ASK YOUR DOCTOR"

CARNATION SINCERELY BELIEVES that the health of our nation's babies is too precious a thing to be left to the well-meant but doubtful advice of friends or relatives.

So year after year, month after month, Carnation advertising messages urge mothers to *go to their doctor* for advice on infant feeding. In an average month, Carnation newspaper, magazine and radio advertising repeats this advice 38 *million times*: "Ask your doctor."

And Carnation is proud to report that this consistent educational program is producing definite results. Here is the evidence:

8 OUT OF 10 MOTHERS USING CARNATION REPORT THAT IT WAS RECOMMENDED BY THEIR DOCTOR OR HOSPITAL.

How Carnation Protects the Doctor's Recommendation. You can prescribe Carnation Evaporated Milk *by name* with complete confidence. Every drop in every can of Carnation is processed with *"prescription accuracy"* in Carnation's *own* plants under Carnation's *own* step-by-step supervision. Carnation Milk is always the same safe source of dependable nutrition for infants.

The Milk Every Doctor Knows

"From Contented Cows"

Menus for September 1949

Ena D. Ostberg
St. Luke's Hospital
Boise, Ida.

1
Grapefruit Half
Popovers

•

Liver and Bacon
With Ketchup
Hashed Brown Potatoes
Creamed Onions
Lettuce With Russian
Dressing
Spice Cake

•

Cream of Mushroom Soup
Barbecued Wieners
Hot Biscuits
Celery and Cabbage Salad
Baked Apple With Cream

2
Cantaloupe
French Toast, Sirup

•

Baked Haddock, Tartare
Sauce
Parsley Buttered Potatoes
Baked Squash
Jellied Cranberry Salad
Pecan Crunch Ice Cream

•

Tomato Bouillon
Egg Salad and Pickle
Sandwiches
Mixed Fruit Salad
Butterscotch Marshmallow
Pudding

3
Orange Juice
Soft Cooked Egg

•

Roast Lamb With
Mint Jelly
Oven Browned Potatoes
With Gravy
Buttered Carrots
Sliced Tomato and
Cucumber Salad
Chocolate Marshmallow
Roll

•

Cream of Asparagus Soup
Link Sausages
Escalloped Corn
Cinnamon Apple Salad
Hermits

4
Grapefruit Half
Bran Muffins, Jelly

•

Southern Fried Chicken
With Cranberry Sauce
Mashed Potatoes With
Gravy
Frozen Peas
Celery and Olives
Butterscotch Sundae

•

Vegetable Soup
Tuna Salad
Potato Chips
Melon Slices
Hot Rolls
Fresh Fruit Cup
Vanilla Wafers

5
Sliced Banana
Bacon Strips

•

Swiss Steak With Gravy
Parslied Potatoes
Cauliflower
Combination Salad With
French Dressing
Blackberry Cobbler

•

Clam Chowder (large)
Deviled Egg With Pickled
Beet Salad
Coffee Soufflé

6
Blended Juice
Cinnamon Rolls

•

Meat Loaf With Ketchup
Baked Potato
String Beans
Apple and Celery Salad
Cottage Pudding With
Orange Sauce

•

Scotch Broth
Escalloped Potatoes and
Frankfurters
Tomato and Avocado Salad
Canned Plums

7
Orange Slices
Poached Egg

•

Pork Chops With
Apple Rings
Mashed Patotoes With
Gravy
Whole Kernel Corn
Perfection Salad
Graham Cracker Pudding

•

Cream of Pea Soup
Hamburger With Bun
Carrot and Raisin Salad
Fresh Pear

8
Cantaloupe
Griddle Cakes, Sirup

•

Roast Beef
Oven Browned Potatoes
With Gravy
Creamed Celery
Lettuce With French
Dressing
Bread Pudding With
Caramel Sauce

•

Vegetable Soup
Chow Mein
Noodles
Mixed Fruit Salad
Cup Cake

9
Grapefruit Juice
Scrambled Eggs

•

Fillet of Sole With
Tartare Sauce
Escalloped Potatoes
Fresh Spinach
Tomato and Lettuce Salad
Banana Cream Pie

•

Cream of Corn Soup
Cheese Soufflé
Tossed Garden Salad
Baked Apple With Cream

10
Tokay Grapes
Link Sausages

•

Lamb Chops With
Pickle Relish
Hashed Brown Potatoes
Baked Squash
Melon Slices
Tapioca Pudding

•

Cream of Asparagus Soup
Italian Spaghetti With
Meat Balls
Coleslaw
Canned Apricots

11
Tomato Juice
Popovers

•

Baked Ham With
Mustard Sauce
Candied Yams
Buttered Broccoli
Grapefruit and Orange
Section Salad, French
Dressing
Chocolate Sundae

•

Beef Broth With Rice
Creamed Chicken on
Hot Biscuits
Watercress and Sliced
Cucumber Salad
Bing Cherries

12
Stewed Prunes
Soft Cooked Egg

•

Braised Beef With
Horseradish
Buttered Noodles
Parslied Carrots
Lettuce Wedge With
Russian Dressing
Boston Cream Pie

•

Split Pea Soup
Fresh Fruit Plate With
Cottage Cheese
Hard Rolls
Gelatin Cubes With
Whipped Cream

13
Grapefruit Half
Sweet Rolls

•

Roast Veal With Dressing
Spiced Pears
Mashed Potatoes With
Gravy
Julienne Beets
Apple, Celery and
Date Salad
Grapenut Custard

•

Mulligatawny Soup
Meat Loaf in Biscuit
Crust With Gravy
Banana Nut Salad
Lime Sherbet
Wafers

14
Orange Juice
Poached Egg

•

Braised Liver With
Ketchup
Creamed Potatoes
Buttered Asparagus
Sunset Salad
Raspberry Shortcake With
Whipped Cream

•

Consommé
Baked Ham and
Lima Beans
Spring Salad With
French Dressing
Cornbread
Pineapple Chunks

15
Cantaloupe
Bacon Strips

•

Roast Beef
Browned Potatoes With
Gravy
Escalloped Cabbage
Tomato and Lettuce Salad
Apricot Whip

•

Cream of Mushroom Soup
Shepherd's Pie
Frozen Fruit Salad
Gingerbread

16
Grapefruit Juice
Blueberry Muffins, Jelly

•

Salmon Steaks With
Lemon Wedge
Baked Stuffed Potato
Buttered Peas
Sliced Orange and
Coconut Salad
Peppermint Stick Ice
Cream

•

Lakeside Soup
Grilled Cheese Sandwich
Asparagus and Pimiento
Salad
Baked Apple With Cream

17
Sliced Banana
Scrambled Eggs

•

Swedish Meat Balls
Parsley Buttered Potatoes
Mashed Squash
Lettuce Wedge With
1000 Island Dressing
Pineapple Upside-Down
Cake With Whipped Cream

•

Beef Broth With
Vermicelli
Vegetable Casserole
Veal Salad
Fruit Cup
Date Bars

18
Orange Slices
Country Sausage

•

Roast Chicken With
Sage Dressing
Cranberry Relish
Mashed Potatoes, Gravy
Green String Beans
Stuffed Celery
Cherry Pie

•

Cream of Corn Soup
Cold Sliced Meat
Potato Salad
Tomato Slices
Hot Rolls
Sliced Peaches

19
Pineapple Juice
Griddle Cakes, Sirup

•

Stuffed Pork Chop With
Spiced Crabapple
Escalloped Potatoes
Mashed Turnips
Tossed Green Salad
Fruit Marshmallow

•

Vegetable Soup
Baked Tuna With
Potato Chips
Grapefruit Sections With
Apple Slices
Oatmeal Cookies

20
Stewed Prunes
Ham Omelet

•

Beef Stew With
Carrots and Onions
Boiled Potatoes
Buttered Cauliflower
Melon Slices
Steamed Pudding With
Hard Sauce

•

Chicken Soup With Rice
Hot Roast Beef Sandwich
With Gravy
Celery, Radishes and
Green Pepper Rings
Seedless Grapes

21
Grapefruit Half
Date Muffins

•

Roast Lamb With
Mint Sauce
Mashed Potatoes With
Gravy
Whole Kernel Corn
Tomato Wedges
Blueberry Cobbler

•

Oyster Stew (large)
Bacon and Cheese
Sandwich
Pineapple and Banana
Salad
Brownies

22
Orange Juice
Bacon Strips

•

Swiss Steak With Gravy
Pan Browned Potatoes
Broccoli
Waldorf Salad
Floating Island

•

Cream of Pea Soup
Stuffed Peppers
Combination Salad
Fresh Plums

23
Honey Dew Melon
Soft Cooked Egg

•

Fried Mackerel With
Lemon Wedge
Baked Potato
Harvard Beets
Pear With Grated Cheese
Salad
Chocolate Meringue Pie

•

Salmon Loaf With
Parsley Sauce
Red Cabbage Slaw
Canned Apricots
Macaroons

24
Tomato Juice
Coffee Cake

•

Chicken Pie
Mashed Potatoes
Buttered Peas
Stuffed Celery
Apple Goody

•

Beef Broth With Noodles
Omelet With Spanish
Sauce
Sliced Banana and
Orange Salad
Coconut Cake

25
Cantaloupe
Link Sausages

•

Broiled Steak With
Pickle Relish
Hashed Brown Potatoes
Julienne Carrots
Lettuce Wedge With
Roquefort Dressing
Strawberry Sundae

•

Corn Chowder (large)
Assorted Cold Meats
Celery Hearts
Cooked Vegetable Salad
With French Dressing
Hard Rolls
Date Bars

26
Blended Juice
Poached Egg

•

Roast Beef
Mashed Potatoes With
Gravy
Browned Parsnips
Lettuce and Tomato Salad
Baked Lemon Sponge

•

Vegetable Soup
Chop Suey
Rice
Frozen Fruit Salad
Toll House Cookies

27
Sliced Banana
Cornmeal Muffins, Honey

•

Breaded Veal Chops
Baked Potato
Mashed Squash
Cucumber in Lime
Gelatin Salad
Fresh Peach Shortcake
With Whipped Cream

•

Chicken Soup
Cheese Dreams
Melon Ball Salad
Baked Custard

28
Tokay Grapes
Griddle Cakes, Sirup

•

Meat Loaf With
Pepper Relish
Escalloped Potatoes
Green String Beans
Apple, Celery and
Date Salad
White Cake

•

Cream of Tomato Soup
Baked Chicken and
Noodles
Grapefruit and Avocado
Salad With French
Dressing
Mocha Soufflé

29
Orange Juice
Bacon Strips

•

Roast Pork With
Applesauce
Candied Yams
Spinach
Celery and Olives
Rice Pudding With
Raisins

•

Mulligatawny Soup
Baked Hash With Ketchup
Jellied Spiced Banana
Salad
Coconut Cream Pie

30
Stewed Prunes
Scrambled Eggs

•

Codfish Balls With Sauce
Parsley Buttered Potatoes
Whole Kernel Corn
Tossed Green Salad
Lemon Sherbet
Sugar Cookies

•

Clam Bisque
Baked Potato
Grilled Tomato
Asparagus Tips
Apricot With Cottage
Cheese Salad
Brownies

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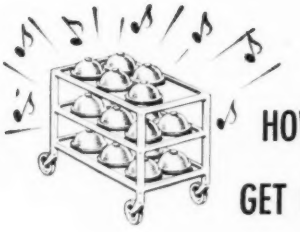

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PUTTING PATIENTS' ROOMS IN THE BEST LIGHT

CHARLES L. CLAY, M.D., and WILLARD ALLPHIN

Respectively, Assistant Director, Massachusetts General Hospital, Boston and Applications Engineer, Salem, Mass.

IN AN effort to determine the most satisfactory methods of lighting for various needs, experimental installations of several types of luminaires were made at the Baker Memorial of Massachusetts General Hospital, Boston. In the first section of this article, various lighting problems were analyzed last month. Following is a description of the changes made in several rooms in order to study the effects of different types of luminaires.

EXPERIMENTAL ROOMS

Before changing, these rooms had for a ceiling luminaire a glass enclosing-globe with a transparent upper portion and translucent diffusing lower portion. It contained a 60 watt incandescent lamp for general illumination and one of 6 watts for night light. A floor lamp with a 60 watt incandescent bulb in a bell-shaped open shade provided light for reading.

MEASUREMENTS

People who arrange luminaires at home do so empirically, locating them where the light will shine on their reading matter, and using wattage enough for comfort. But for our purposes the amount of the illumination, and the brightness of the objects upon which it falls, must be measured in terms which permit our comparing the results of one method with those of another mathematically. The amount of illumination we express as foot-candles.

A standard candle at a distance of 1 foot from a surface throws 1 lumen of light per square foot upon that surface and the surface is therefore illuminated to a level of 1 *foot-candle*. Any surface which emits or reflects 1 lumen per square foot has a brightness of 1 *foot-lambert*. Thus the brightness of a reflecting surface is the product of two factors: illumination and reflectivity. For example, if a surface of 40 per cent reflectivity is illuminated to a level of 20 foot-candles, its brightness will be 8 foot-lamberts. Foot-candles, then, measure the amount of light falling on an object, *e.g.* the wall; foot-lamberts, the amount of (1) emitted light from a source, or (2) reflected light (glare, if the FL figures are high) which we get from the object illuminated, as we view it.

Of the following sample foot-lambert values, four pertain to common *sources* of light; the sky is really only a reflector, as is the moon.

Sun, at meridian, as observed from earth's surface . . 483,000,000 FL
Moon, bright spot as observed from earth's surface . . . . . 740 FL
Clear sky, average, as observed from earth's surface . . . . 2,300 FL
Overcast sky, as observed from earth's surface . . . . 650 FL or less
Kerosene flame, flat wick 3,530 FL
60 watt inside-frosted incandescent bulb . . . . . 27,000 FL
40 watt white fluorescent bulb . . . . . 1,830 FL

MEASUREMENTS IN A PATIENT'S ROOM

A typical room setup as described, and with the reading lamp at the customary angle, had the amounts of illumination and brightness shown in table 1. (Brightness read from the patient's position in the bed unless otherwise stated.)

Two comments are suggested by these figures: The reading illumination is insufficient and the contrast between the brightest and dimmest parts of the visual field is too great for comfort.

EXPERIMENTAL INSTALLATIONS

Five different arrangements were tried:

1. Torchiere (incandescent).
2. Pin-up wall luminaires in a single room (fluorescent).
3. Pin-up wall luminaires in a double room (fluorescent).
4. Ceiling luminaire (fluorescent) and reading lamps (fluorescent) on adjustable arms in a double room.
5. Ceiling luminaire (fluorescent) and bull's-eye (incandescent) reading lamps on adjustable arms for two beds in a four-bed room.

Because these were only experimental the existing wiring was disturbed as little as possible. The pin-up luminaires were fed from existing wall outlets, and the night lights were left in place.

1. Room 425 (fig. 5) is a private room approximately 9 by 12 feet with a 9 foot ceiling. The walls are pale green. All the illumination comes from a torchiere (fig. 6) with an incandescent 50-100-150 watt bulb. A bull's-eye lens in the reflector sends a beam of light downward at an angle of 30

Table 1—Illumination and Brightnesses in Typical Room

	General Lighting	*General Lighting Plus Reading Light*
Horizontal illumination at center of bed	3.5 FC	6.5 FC
Illumination on 45° reading plane	3.0 FC	11.5 FC
Maximum ceiling brightness	40.0 FL	40.0 FL
Minimum ceiling brightness	0.6 FL	0.6 FL
Brightness of facing wall	2.0 FL	2.5 FL
Brightness of head wall	2.0 FL	2.5 FL
Luminaire brightness toward patient	120.0 FL	27,000.0 FL*
Luminaire brightness toward visitor	120.0 FL	27,000.0 FL*

*Not in patient's field of view, but frequently in visitor's.

Photos, courtesy of Sylvania Electric Products, Inc., Salem, Mass.

Left: Figure 5 shows private room lighted by a torchiere with a spotlight for reading. Right: Figure 6. Turning the knob outside the torchiere closes the shutter of the spotlight.

degrees from horizontal. A sleeve helps the lens confine the beam to a spread of about 25 degrees and has a suitable disk shutter operated by a knob.

With the shutter open and the torchiere located for reading, the indirect component gives more favorable brightness ratios than would be obtained with the spotlight alone. When the shutter is closed and the torchiere is being used only for low-level general lighting the nurse can move it farther away from the bed if the brighter portion of the ceiling disturbs the patient.

The direct beam from the torchiere serves for physical examinations whenever its direction of light is suitable. In other cases the nurse brings in a portable lamp. For postoperative illumination the 50 watt filament is used with the shutter closed and part of the reflector opening covered.

A convalescent patient can move the torchiere so as to read in the easy chair.

The principal disadvantages of the torchiere are the bright spot on the ceiling and the bother of having a luminaire standing on the floor. On the other hand, it has much to recommend it for simplicity and flexibility since the bed can be placed anywhere in the room. Patients who used this torchiere liked it, and found the reading illumination (24 foot-candles) comfortable. The brightness of the reading matter is more nearly that of the ceiling (37 foot-lamberts) than was the case with the original installation where the book illuminated by 11.5 foot-candles competed with the luminaire brightness of 40 foot-lamberts.

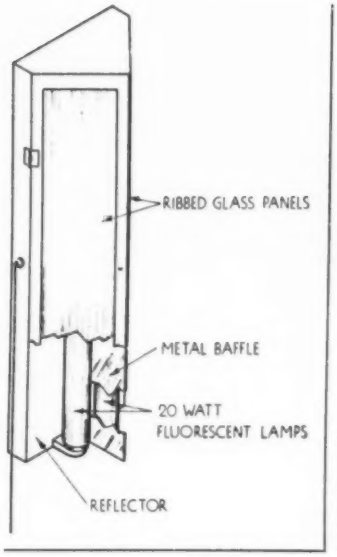
Figure 7 shows a two-way pin-up installation in a private room. The walls are finished in pale green.

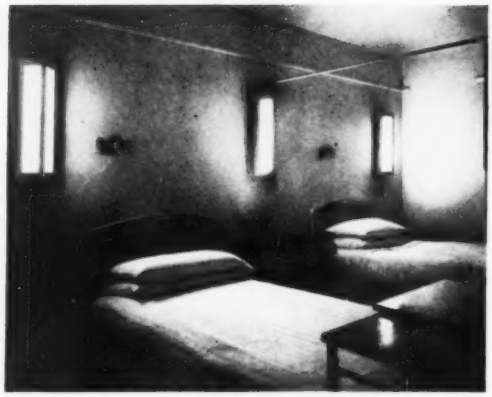
2. Room 428 (fig. 7) is a private room, 9 by 12 feet with a 9 foot ceiling. The walls are finished in pale green. The lighting is from a pair of two-way pin-up luminaires (fig. 8) mounted vertically on the wall at the head of the bed, 4 feet apart with centers 5 feet 8 inches above the floor. Each one contains two 20 watt fluorescent tubes separated by a baffle, and concealed by diffusing glass panels. The outer pair of tubes is used for room illumination; they are completely hidden from a recumbent patient. For reading in bed the inner pair is used. The baffle previously mentioned stops a little short of the reflector, allowing some light to leak past for illuminating either panel just a little when the other side is lighted. Both tubes of a single luminaire can be used for reading in a chair or, if preferred, a portable lamp can be brought in, as must be done for physical examinations when directional

Table 2—Illumination and Brightnesses With Watt Filament—Room 425

	General Lighting	General Plus Reading Light
Horizontal illumination at center of bed	5 FC	7 FC
Illumination on 45° reading plane	6 FC	24 FC
Maximum ceiling brightness	37 FL	37 FL
Minimum ceiling brightness	2 FL	2 FL
Brightness of facing wall	3 FL	3 FL
Brightness of head wall	32 FL	32 FL
Luminaire brightness toward patient (but not in normal field of view)	.....	700 FL
Luminaire brightness toward visitor	.....	200 FL

With the 100 watt filament in use these figures would be reduced by slightly more than one-third.





Left: Figure 8. Detail of two-way pin-up luminaire in figure 7. Right: Figure 9. Three pin-up luminaires serve to light a semiprivate room.

light different from that afforded by the wall luminaires is necessary.

Table 3—Illumination and Brightnesses—Room 428

	General Lighting	*General Plus Reading Light*
Horizontal illumination at center of bed	2 FC	8 FC
Illumination on 45° reading plane	4 FC	24 FC
Maximum ceiling brightness	6 FL	10 FL
Minimum ceiling brightness	2 FL	5 FL
Brightness of facing wall	2 FL	7 FL
Brightness of head wall	1 Fl	12 FL
Luminaire brightness toward patient (but not in normal field of view)	50 FL	1200 FL
Luminaire brightness toward visitor	1200 FL	1200 FL

A brightness of 1200 foot-lamberts may seem rather high to present toward a visitor in his central field of view, but in actual practice, with the high reflection factors used in hospital rooms, the effect is not annoying. The inner panels are not ordinarily lighted unless the patient is sitting up, in which case they are partly behind him and are thus not a source of glare for him.

This installation was used as a test of color, as the green walls offered a good chance to observe the effect. White fluorescent lamps were selected and no adverse comments were received about either color of the light source or the appearance of the patient and of the elements of the room. Use of the new warmtone lamps to yield a light similar in color to that of incandescence will solve this problem for anyone who considers white too cold.

3. Room 436 is a semiprivate room approximately 9½ by 16 feet with a 9 foot ceiling. The walls are finished in light buff. The lighting arrangement (fig. 9) is basically the same as for the room last described except that three luminaires are necessary. Each patient controls the pair of tubes nearest his bed for reading, while the outer pair, or as one might say, No. 1 and No. 6, are used for simple room illumination. It will be seen that one of the tubes used for reading is directed toward the other patient's bed as well, yet this produced no complaints, probably because distance reduced the effect of its light.

Table 4—Illumination and Brightnesses—Room 436

	General Lighting	*General Plus Reading Light*
Horizontal illumination at center of bed	2 FC	9 FC
Illumination on 45° reading plane	3 FC	20 FC
Maximum ceiling brightness	7 FL	10 FL
Minimum ceiling brightness	1.5 FL	5 FL
Brightness of facing wall	2 FL	8 FL
Brightness of head wall	2 FL	16 FL
Luminaire brightness toward patient (but not in normal field of view)	50 FL	1200 FL
Luminaire brightness toward visitor	1200 FL	1200 FL

The general effect of this setup is about the same as that in Room 428.

4. Room 433 (fig. 10) is a two-bed room, 12 by 16 feet with a 9 foot ceiling. The walls are finished in light buff. A central luminaire suspended 6 inches below the ceiling contains two 40 watt fluorescent lamps. The standard design of this commercial unit has been changed by the addition of a vertical diffusing glass baffle running the length of the luminaire in the lower part of the V, (fig. 11) and by the addition of a switch to turn off the lamp on the side toward the patient. When it is off, the baffle permits only a small amount of light to reach the diffusing glass panel on the side nearest the patient, giving it a brightness not more than five times that of the ceiling near it.

For general illumination the tube away from the patients is used alone. It gives some indirect lighting throughout the room, with a direct component, not enough to be disagreeable, on the facing wall. The tube toward the patients was intended for physical examinations, supplemented by the reading luminaires, but in practice the latter proved to be not only adequate for it by themselves, but more convenient. They are wall mounted luminaires carrying two 15 watt tubes on brackets. The radius of their swing is 2½ feet, and their position 58 inches from the

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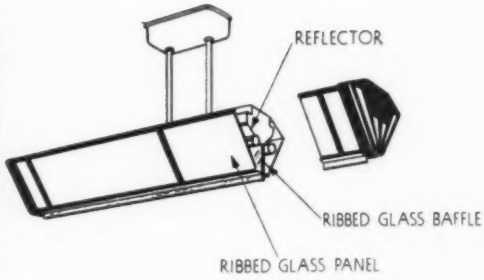

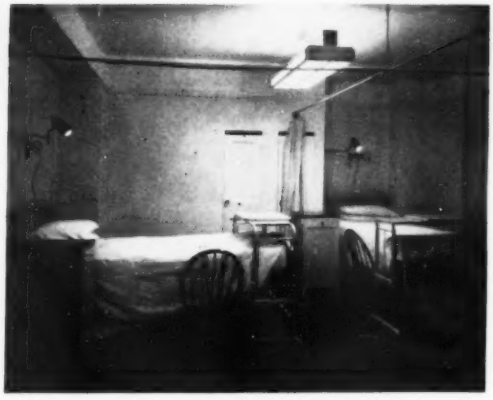

Left: Figure 10. Suspended luminaire with wall auxiliaries. Above, right: Figure 11. Detail of suspended luminaire in figure 10. Below, right: Figure 12. Combination fluorescent and incandescent lighting was used.

floor permits reading with the head of the bed at 60 degrees without casting any shadow on the book. When swung away from the bed the position of this lamp is correct for reading in an easy chair beside the bed. For the sake of safety the bracket swings in a horizontal plane only, and the reflector has a strap to prevent complete rotation so as not to twist the wires.

The illumination for reading, about twice that of the brightest of the other installations, is no more than recommended by some practicing engineers for continuous reading. Some of the patients liked it, but there was a difference of opinion, of which the extremes were one patient whom we found lying on his back reading with the lamp directly in front of his face, and another who demanded a bell-shaded floor lamp instead. This situation could be controlled by a switch for giving a choice of one or both tubes. The doctors were especially pleased with the two-tube illumination for physical examinations.

5. Room 438 (fig. 12) is a four-bed room 16 by 25 feet with a 9 foot ceiling. The walls are finished in pale peach. It can be regarded as two two-bed rooms thrown together. Each end has its own separately controlled illumination. For replacing the ceiling lights we used standard suspended luminaires with glass side panels and louvered bottom carrying four 40 watt fluorescent tubes. All four are used for physical examinations, but for ordinary general illumination only the inner pair are necessary. The outer pair, being off, then act as baffles.

For reading we installed wall-mounted bull's-eye lamps with 60 watt incandescent bulbs on brackets 68 inches from the floor. Their radius of swing is 22 inches; the lamps are pointed at an angle of 45 degrees down from horizontal and rotate. Thus they provide for any reading position, but a limit pin restricts their play to an area where the beam will not reach any other patient's eyes, either to the side or in front. They are demountable, and could be used as accessory lights for physical examinations, but only with care as the shells soon get hot.

The outer pair of tubes in the ceiling luminaire in Room 438 add 7 footcandles to the illumination at the center of the bed.

Table 5—Illumination and Brightnesses—Room 433

	General Lighting	*General Plus Reading Light*
Horizontal illumination at center of bed	4 FC	32 FC
Illumination on 45° reading plane	2 FC	46 FC
Maximum ceiling brightness	55 FL	56 FL
Minimum ceiling brightness	1 FL	3 FL
Brightness of facing wall	5 FL	6 FL
Brightness of head wall	2 FL	8 FL
Luminaire brightness toward patient (in field of view)	250 FL	250 FL
Luminaire brightness toward visitor	1100 FL	1900 FL

Table 6—Illumination and Brightnesses—Room 438

	General Lighting	*General Plus Reading Light*
Horizontal illumination at center of bed	7 FC	14 FC
Illumination on 45° reading plane	4 FC	35 FC
Maximum ceiling brightness	50 FL	54 FL
Minimum ceiling brightness	2 FL	5 FL
Brightness of facing wall	3 FL	5 FL
Brightness of head wall	5 FL	8 FL
Luminaire brightness toward patient	480 FL	480 FL
Luminaire brightness toward visitor	2100 FL	2100 FL

This is the second section of a study of lighting for patients' rooms. The third section will appear in the September issue.

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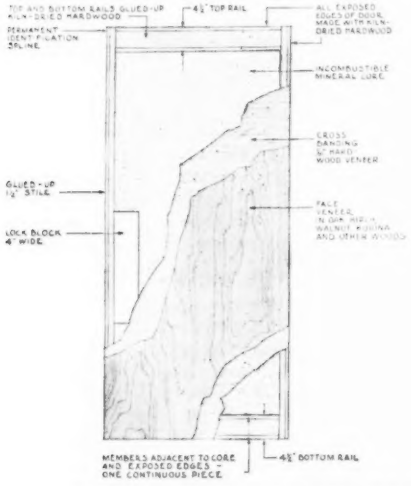

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FIRE PREVENTION is the housekeeper's business

EDWARD N. MONTGOMERY
Deputy Chief in Charge, Fire Prevention Division, Boston Fire Department

THERE is no mystery about fire. It is merely the carrying out of a natural chemical process. We see it going on about us all the time. The rotting tree in the woods or a rusting piece of metal is being subjected to identically the same chemical process as a flaming piece of paper or a sparkling fire in the fireplace. The difference is one of time.

Following the immutable law of nature, there must be three elements to have a fire or oxidation of a material. First, there must be burnable material —fuel; second, there must be oxygen; third, there must be a source of ignition. It is the last of the three which causes the most concern. All about us—in our homes, offices, schools, in fact, our very clothing—we find the first necessity for a fire. The same applies to the number two component. Therefore, it is almost impossible to remove either of these two. The third is *ours* to control. Individually, we may do this by the exercise of caution and care. However, we may not be able to control the action of our neighbor who may well provide the third element of the triumvirate which produces fire.

WHERE FIRES ORIGINATE

Here we enter the domain of good housekeeping. Since we cannot have a fire without all three of the elements, the elimination of any one will be positive fire prevention. To have a fire, we must have fuel. In thousands of cases, this is inadvertently provided by careless or thoughtless housekeeping. Countless fires originate in waste material, in dark closets, in cellars and attics, and in storerooms. The cause? A carelessly tossed cigarette or burning match (*ignition*) lands on paper, clothing, waste or rubbish (*fuel*). Now we have two-thirds of the necessary elements which we ourselves provided. All that is needed is oxygen and that is all about us. The combination is complete; hence, a fire must occur. At this point, I again emphasize that we cannot have a fire unless fuel, oxygen and a source of ignition are brought into combination. Please keep that in mind because it is only by doing so that fires can be prevented.

It is not necessary that the heat, or ignition, required to ignite the fuel come from a visible flame, spark or glowing ember. It is quite possible to provide both fuel and the source of heat without the latter's being detected. Certain chemical processes or bacteriological changes may produce heat of their own accord when in contact with the proper material. This is known as spontaneous ignition. Perhaps the best known examples are the fires caused by self-ignition of rags used in connection with floor waxing, paint rags, cleaning rags used with turpentine or similar fluids, and so forth.

Contrary to general opinion, such liquids as gasoline, naphtha or other dry cleaning fluids are not susceptible to the processes which generate heat. However, linseed, coconut and fish oils are subject to spontaneous heating to a high degree. Any combustible material contaminated with these oils is subject to rapid oxidation under many of the conditions that prevail in hospitals, hotels and similar establishments. It is a cardinal principle of fire safety that all material which has been even slightly contaminated should be destroyed at once or kept in closed metal containers. To do otherwise is to invite trouble.

In this issue we resume the "reading course" from the series of lectures presented at Boston University and sponsored jointly by the Massachusetts Hospital Executive Housekeepers Association and the National Executive Housekeepers' Association

It is a sad commentary on a housekeeper to say that to make a floor look well she burned a building. Lest you think that this picture is overdrawn, I want to tell you of an actual occurrence in my own experience. Some years ago, as a new lieutenant, I inspected a large building in this city. There was every evidence of careful housekeeping throughout. The custodian was most meticulous in disposing of rubbish in an approved manner. During my inspection, I came upon a closet under the stairs from the first to the second floors. In this were kept floor polishes, wax and other articles used in the care of floors. The closet itself was tightly closed. At the head of the stairs was a steam radiator, the pipes for which passed through the closet. To one in the fire service, it was a perfect setting for a fire since all necessary requisites were provided for spontaneous ignition.

"NEVER HAD A FIRE"

When the custodian's attention was called to this condition, he did not take it seriously. As a matter of fact, his answer was—"I've been keeping those things in there for over 20 years and we've never had a fire." Training and experience prompted me to reply that there would only be one fire if it originated in that closet. He did, however, promise to find a safer place. Less than two weeks after I had spoken to him, a fire did start in the closet. Today there is a large parking lot on the site of that building! If floor oils, waxes, sweeping compounds, furniture,

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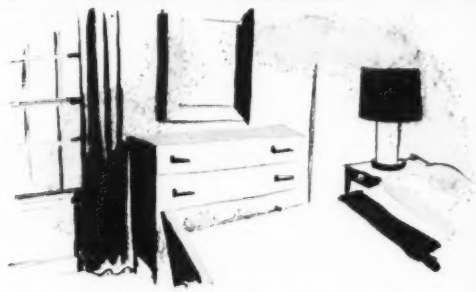
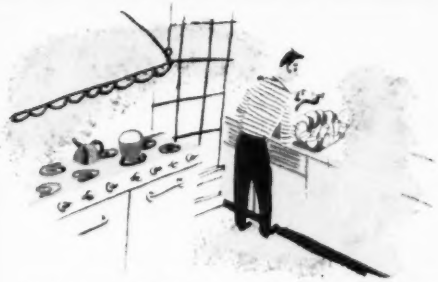
Along the corridors—Along the long, busy hospital corridors, there are many cleaning problems. To keep the corridors shining, use HOSPITAL GREEN SOAP. Put FORMULA NO. 99 ANTISEPTIC SOAP in the operating room for surgical scrub up. (Remember Armour's GLYCERINE in the hospital pharmacy.)



To the patient's room—To keep the patient's room light and bright there's: REGAL DETERGENT for the mirrors and windows—NO. 422 SYNTHETIC DETERGENT for the walls—ROYAL FLAKES for the blankets and bedspreads. And put a bar of CLIPPER in every room for the patient's own use.



And from the kitchen—To help maintain the high sanitary standards of your kitchen, there's LIGHTHOUSE WASHING POWDER. To lighten the work of your kitchen staff there's NO. 422 SYNTHETIC DETERGENT—and for spotless ranges, pots and pans, there's LIGHTHOUSE CLEANSER and TOPAZ CHIPS.

To the laundry—Your laundry, too, has high standards of cleanliness to maintain. To keep your linens really white, use FLINT CHIPS. And there's HILO POWDER for your colored work. For your heavy laundry work, try GIANT POWDER, the ready-built soap made to stand up under high temperatures.

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metal or stove polishes are used, it is always well to remember that they are probably subject to spontaneous heating. Treat them as potential fire hazards.

Now please do not think that most fires in institutions are caused by careless or poor housekeeping. They are not. For your information, I present these figures: Nearly half, or 41 per cent, of fires in hotels are attributed to smoking and matches. Heating defects and the misuse of electricity cause 27.5 per cent and 31.5 per cent are from causes which may be fairly charged to poor housekeeping. Of this number, kitchen hazards, spontaneous ignition, inadequate rubbish disposal and the use of flammable liquids account for 16.5 per cent. This is the fire record for a period of 10 years.

HOW TO PREVENT SPREAD

There is no necessity for me to speak on the record of fatalities in hotel and hospital fires. We are all aware of recent events in that line. Now let us see how good housekeeping and the practice of observing things may help to reduce the number of fatalities. When a fire starts, it always trys to extend itself. The most natural way for this extension is by the way of vertical openings. Following the series of hotel fires, building officials realized what fire prevention officials had long known—that to prevent the spread of fire, it must be cut off from either vertical or horizontal openings. This is done by the use of enclosed stairways, elevator wells, air shafts and the like, also by fire doors between sections or in corridors.

Perhaps the most effective way of confining a fire to a single section of a building is the use of fire doors. There are several types, the most familiar of which are the self-closing and automatic closing doors. The first is the door which is pushed open and then closes. The second is one that is held open by a fusible link. When subjected to about 160° F. of heat, the link melts and releases a weight which closes the doors. Both types are effective when permitted to operate as designed. However, unless properly maintained, both are useless when a fire occurs. Failure of fire doors to operate is one of the most prolific causes of small fires developing into large fires.

We all know that it is much easier to pass through an open door than it is to open it. This is especially true when one has to push laundry baskets, meal trays and vacuum cleaners or to carry large articles from one section to another. To provide greater convenience in doing these things, the purpose of the fire door is forgotten and the door is fastened open. During many inspections of hotels, hospitals and similar institutions, I have found this to be a general practice. I have often wondered who had time to make the wedges jammed under the doors. Indeed, I recollect one inspection during which I acquired 16 wedges that I left on the manager's desk. In one of our largest hospitals, I found four self-closing doors held open with brass hooks. This is a dangerous practice and should not be tolerated.

Let us now consider the automatic closing doors. This type will operate, but its success depends upon its ability to make a secure closure. It cannot do so if its travel is in any way obstructed; therefore, any obstruction should be promptly removed. I fully appreciate that it may be difficult to prevent these things from happening, particularly where many employes are involved, but proper operation of fire doors is a safety "must" and should be so treated.

The virtues of cleanliness have been well expounded for many years, yet, despite this, one of the trouble spots in hotels, hospitals, institutions, clubs and such occupancies is the kitchen. During the years 1941 to 1945 there were about 12,700 fires, with a loss of $2,450,000, which originated in grease flues, hoods and other equipment designed to prevent fire by providing ventilation to carry the hot fumes away. These are preventable fires and can be eliminated by regular cleaning. I am pleased to say that one of the safest kitchens, from the standpoint of grease fires, I have ever seen is at the Massachusetts Memorial Hospital. Another is at Boston University's own Charlesgate. Kitchens can and should be kept clean.

Now to deliberate on the use of electric appliances. When we turn on the light switch or the vacuum cleaner, the fan or any of the other appliances which are part of modern living, we should keep in mind that there is a giant generator on the other end of the wires, not a series of dry cells. Electricity is heat as well as power. It may be very useful or equally dangerous—which it is depends upon how we treat it. Frayed wires, faulty switches, lazy motors—all are potential fire hazards. The slightest defect should be reported at once and the appliance should not be used until it has been properly repaired.

Not too long ago a fire occurred in a Boston hotel. Since the cause appeared to be somewhat mysterious, we made a very thorough investigation. This fire originated in a closet. When the debris was overhauled, the remains of a vacuum cleaner were uncovered. Further investigation disclosed that it had been used several hours previous to the fire. From there we made a check on the cleaner and found that it had not been working properly so had been sent out for repairs. On its return, presumably in good condition, it was placed in service. The maid, who had used it several times, told us that it seemed to get very warm, but since she knew it had been repaired, she thought nothing of it. However, the last time she used it, she noticed that it gave a very hot odor so she stopped and put it in the closet. Had she been instructed to report such things to her superiors, the fire would not have taken place.

I have given you a resumé of some of the commonest causes of fire and could give you many more. As to how fires can be prevented, may I say that a clean, well supervised establishment seldom burns.

CAUSE OF FATALITIES

I would now like to discuss the cause of the many fatalities that have attended fires in the occupancies in which we are interested. That cause is undoubtedly the *delayed alarm*. We firemen cannot know that there is a fire until an alarm has been received. We must await the alarm but the fire does not await our arrival at the scene. I want to be specific on this point and regardless of how it may affect anyone, I say with all sincerity and with all the force at my command that the great loss of life in recent hotel fires was directly caused by the failure of someone to send an alarm to the public fire department. Complete investigations of these fires have established that fact beyond contradiction. It is criminal to delay an alarm of fire, notwithstanding the comfort of guests. It is so much better to awake an entire building needlessly and have folks walk back to their rooms than to try to extinguish a fire until it has gotten out of control—when an alarm may be too late. Much better to have the guests walk out

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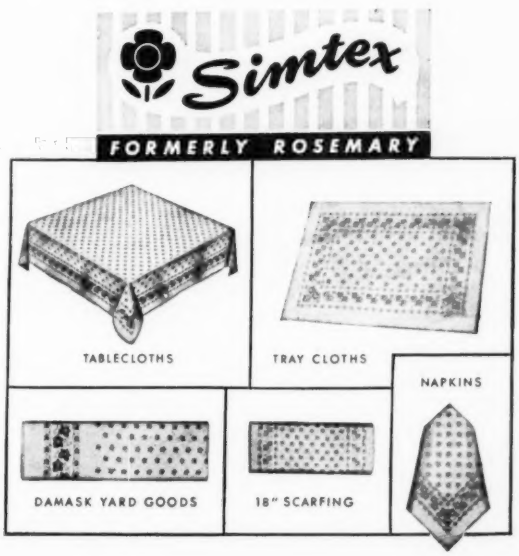

than be carried out! The executive housekeepers may have little or no control over such matters but they can be missionaries spreading the doctrine of immediate alarm. Just to illustrate an actual fact I saw a pamphlet called "What to Do in Case of Fire." I was amazed to see that six officials were to be notified—the fire department was *seventh* on the list. Now, this should not be. The very first thing to do in case of fire is to notify the fire department. After that is done is the time to start to extinguish the fire.

In the various institutions with which you are connected, there are fire extinguishers. You see them hanging on the walls or standing in corners. Do you know what kind of extinguishers they are? For what type of fire they are best? There are three classes of fire extinguishers, *i.e.* A, B and C. The *Class A* extinguisher is the one with which you are probably most familiar. It is sometimes called the soda and acid type because its ingredients are bicarbonate of soda and sulphuric acid. Its action is due to the chemical action of both ingredients generating a pressure gas that expels the fluid. This extinguisher is used on fires in ordinary combustible materials where quenching and cooling effects are of first importance.

The *Class B* extinguishers are generally used on fires in flammable liquids, greases and so forth where a blanketing effect is desired. These are usually foam type which closely resembles the Class A in form. The *Class C*, or vaporizing liquid type, is used on electrical equipment where the use of a nonconducting agent is of primary importance. An example of this type is the pump extinguisher. Each has its own special use, although each may also be used on all types of fires, except the electrical fire, with varying degrees of success. Instruction should be given to those who may be called upon to use them.

Fire extinguishers are merely first aid equipment. They are not, nor were they intended to be, substitutes for a fire department. Their use should in no way delay an alarm which would call the public fire department. When fire does occur, nothing takes the place of training and instruction given before the fire. In the beginning, I said that there is no mystery about fire. We know what it will do and how it does it. We are its masters if we but observe the fundamental rules of safety and common sense. When fire does occur, remember these rules:

1. Keep your head and control your emotions. Panic is the greatest ally of fire.
2. Notify the local public fire department. Extinguishing fires is its business.
3. Warn all residents.
4. If possible, bring first aid equipment into operation. Care and caution must be exercised by those who use it.
5. Remember that your first duty is to those whose lives might be imperiled—not to the material things involved.

In closing, I shall tell you a short story. Just before Christmas, I had an 11 year old girl visiting at my home. Like many other children, she sometimes "baby sits" next door to her home in Natick. We talked of fires and what she would do if one happened while she was baby sitting. After some discussion, I said, "Now, Hanna-Jo, do you know why so many people lose their lives in fires?" Her answer came in words of great import: "They just don't think!" There is the exact cause. Panic, the great destroyer, is spawned by those who don't think.

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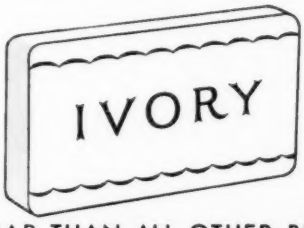

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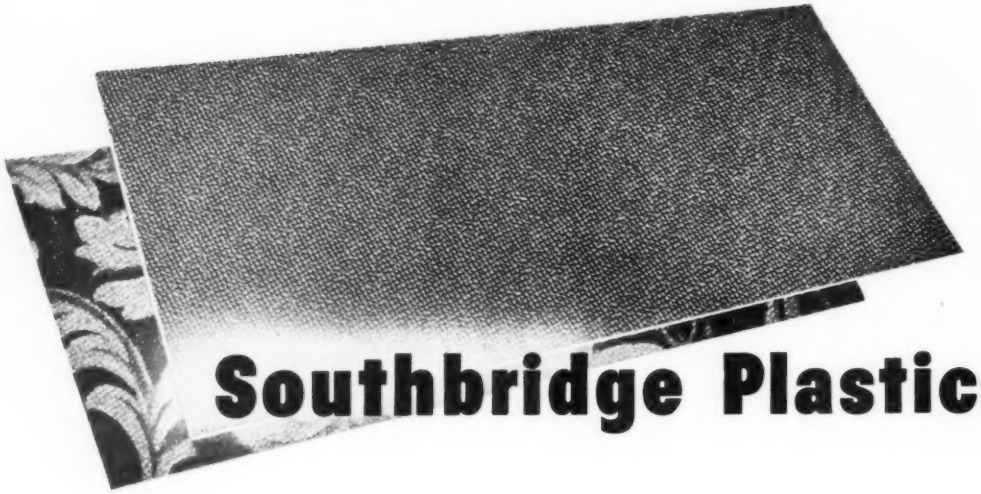

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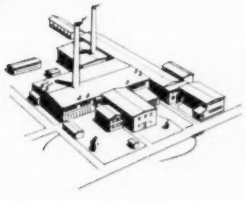

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Federal Hospitalization—*Ginzberg*

(*Continued From Page 74.*)

constructing its general hospitals in inaccessible locations, thereby adding to its own problems, and complicating the problems of the Veterans Administration. There is some truth to the statement that the general hospitals of the army were poorly located, but the presumed explanations or lack of foresight and political maneuvering are not adequate.

During the early part of the war the army expected its general hospitals to give definitive treatment to those patients who required a higher level of skill and facilities than was available at the station hospitals. Since most of the large training centers were located in the South and Southwest, there was a tendency to locate the general hospitals within these areas. But the primary mission of the general hospital during the period of active hostilities was to receive the more seriously sick and injured evacuees from the theaters of operation.

DISTRIBUTION WAS SKEWED

Since the homes of these casualties were distributed more or less according to the pattern of civilian population from which the forces were drawn, and since it was recognized to be desirable to hospitalize patients as close to their homes as possible, the attempt was made to locate the general hospitals in areas with the heaviest density of population — the Northeast, the Mid-Atlantic, and the North Central states. For a time security regulations precluded the acquisition or building of any hospital within 150 miles of the Atlantic Coast, and this prohibition contributed greatly to skewing the eventual distribution. This skewness can be illustrated by the fact that whereas 22 per cent of the population resided in the South and Southwest, 34 per cent of the general hospital beds were located in that area; while the Northeast, with 35 per cent of the population, obtained only 25 per cent of the beds.

When the Veterans Administration was forced to acquire army and navy hospitals, it had no option but to take the best of the available selection within the limits of certain pressures. Among the most potent of these pressures was the concern of a few powerful Congressional leaders to have a Veterans Administration facility in their districts.

The temporizing measures which had succeeded in holding the medical service of the Veterans Administration together during the war years were hopelessly inadequate to cope with the stresses and strains of the postwar period. The experts were not surprised therefore when one of Mr. Truman's first acts as President was to change radically the administrative structure of the Veterans Administration, with major emphasis on changes in the "high command." Although the President and the public were probably convinced that new blood could make a contribution to every phase of the Veterans Administration, they were primarily concerned with a "new deal" for medicine. The fact that the new administrator, General Bradley, was able to persuade Gen. Paul R. Hawley to accept the position of chief medical director of the Veterans Administration was a good augury.

The transformation in the medical service of the Veterans Administration during the past few years has been so great that it is hard to appreciate the extent of the reforms. First and foremost, Generals Bradley and Hawley let it be known that their objective was to provide a high quality of medical care in Veterans Administration hospitals and that they were determined to do what they could to accomplish their objective. This approach was perhaps the greatest break with the past, for whatever might have been the preoccupation of Congress and former administrations in the Veterans Administration it surely had not been the provision of a high quality of medical care. Congress considered its duty discharged when it provided liberal funds for the erection of superior hospitals — they were the best when measured solely in terms of brick and mortar. And the administrators within the organization concentrated in latter years on keeping operating expenses low and avoiding the misuse of public monies.

Having established for themselves the objective of a high level of medical care, Generals Bradley and Hawley had to surmount a host of serious obstacles. Hawley's first and perhaps most important move was to gain the support of important leaders of civilian medicine, by bringing some of them into his office as his principal advisers and by persuading others, particularly the deans of medical schools, to assume supervisory responsibilities for the professional work in Veterans Administration hospitals in their respective areas.

General Hawley's courting of the deans of the medical schools was undertaken not only to provide him with a major lever for raising the professional standards in Veterans Administration hospitals but, equally important, to assist him to obtain adequate numbers of specialists and teaching consultants. The deans took on the major responsibility for providing senior staffs for the Veterans Administration hospitals, largely on a part-time basis.

COMPREHENSIVE REFORM PROGRAM

These were essential steps, but the reform program was much more comprehensive. Aware that the Veterans Administration had never been able to attract any considerable number of competent doctors because of the large differential between the salaries established by Civil Service and the earnings of competent private practitioners in civilian life, the reform administration threw its full weight behind Public Law 293 which would permit the Veterans Administration to hire medical personnel without reference to Civil Service rules and regulations. Although bitterly fought by various agencies in the executive branch of the government, the bill which a sympathetic Congress had passed was signed by the President.

A further facet of the reform program was the establishment of a comprehensive residency program covering 24 fields of specialization. In the second half of 1948 there were approximately 2500 residents actively assigned to Veterans Administration hospitals. Vacancies in the training program were limited primarily to psychiatry and anesthesiology. This

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broad program had a two-fold advantage: first, it established the Veterans Administration hospitals as teaching hospitals and thereby increased their attractiveness to the medical profession; further, it contributed materially to the alleviation of the personnel shortages. A resident staff with part-time consultants can carry the bulk of the work load, or at least a large part of it.

Convinced that a low cost per patient day was a poor index of efficiency, the new administration sought to improve the quality of care as well as the efficiency of the entire system by increasing the amount spent for professional and other services, particularly for the use of diagnostic procedures, a better quality of food, and a larger number of ancillary personnel.

Within a period of three years the hospitals of the Veterans Administration have been thoroughly reformed. Tremendous progress had been made toward the accomplishment of the basic objective of providing the best medical care for veterans. There has been no transformation of such magnitude in the medical history of this country. But despite phenomenal success, serious problems remain.

ISOLATED HOSPITALS HANDICAPPED

Although the basic reform measure —the establishment of the residency program under a deans' committee— proved practical in the majority of hospitals, there was a considerable number of older hospitals, as well as a limited number of newer ones both on transfer from the army, which were so poorly located that it was impractical to elicit the effective cooperation of a medical school. Distance proved an insuperable hurdle. These isolated hospitals have been severely handicapped. They have been short of personnel; they have been short of consultants and specialists, and they have not been able to benefit from the professional revolution which the teaching hospitals experienced.

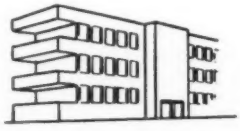
As far as the system as a whole is concerned, its inability to fill its psychiatric residences is a serious handicap since so large a percentage of its patients require psychiatric care. Here the major obstacle has been the absence of adequate opportunities for the young psychiatrist to obtain a personal analysis in isolated communities. The isolated hospital has proved a further handicap. Although since 1945 the new administration has found it possible to staff most of the 25,000 beds which have been added to the system, approximately 4000 to 5000 available beds are currently not in use because the administration has been unable to obtain the requisite number of personnel.

As far as the future is concerned, however, the basic problem of the Veterans Administration will be found in its success, not its shortcomings. The superior quality of medical care which the Veterans Administration is now providing in almost all of its hospitals is the certain guarantee that it will be under continuing pressure to provide an increased amount of such care, until it meets at least the major demands of approximately 20,000,000 veterans. Despite the rapid expansion of the system from approximately 70,000 beds in 1944 to more than 102,000 in the middle of 1948, the Veterans Administration declared ineligible or otherwise failed to provide hospitalization for more than two applicants out of every five in the year 1948. By the advances which it succeeded in making since the end of the war, the Veterans Administration solved a host of serious problems only to find additional pressure —beyond that of a fivefold increase in potential recipients of hospital care—arising out of its own excellence.

Less spectacular but perhaps equally momentous has been the reform in the medical services of the armed forces, particularly the army, since the end of the war. It is well to recall certain basic facts which set the framework in which the reforms had to be evolved. Prior to World War II, the medical department of the army had to provide complete medical care for less than 200,000 military personnel and partial care for a considerable number of their dependents.

Long before the end of the war it was reasonably certain that the postwar strength of the army would be well in excess of the prewar figure. Aware that his regular corps would be inadequate in number and quality to cover the medical service of a vastly expanded army and air force, the surgeon general during the war repeatedly requested permission to add to the regular corps in order to build up its strength when it was most feasible, when a large number of doctors were temporarily separated from civilian life and civilian practice. The general staff, desirous of developing a single policy for integrating officers into the postwar army, refused the request of the surgeon general, with the result that he was unable to start his recruitment until the vast majority of doctors had returned to civilian life. The navy was more fortunate. It succeeded in adding strength throughout the war.

It is not surprising therefore that the first and second "integrations" yielded a very small number—only about 375. The losses from death, retirement and other forms of attrition had been so considerable and the results of the recruitment drive so inconsiderable that it was not until the summer of 1948 that the strength of the regular corps was in excess of what it had been in 1940.



PARALLELED V.A. REFORMS

In many respects the reform program of the army paralleled that of the Veterans Administration. The armed forces recognized that they were at a serious disadvantage in procurement because of the widespread differential between governmental pay and civilian earnings. There had been no basic adjustment in army salaries since prior to World War I! The medical advisory committee to the Secretary of War under the chairmanship of Dr. Edward Churchill recommended special salary legislation which after considerable opposition within the armed forces and other executive departments was finally submitted to Congress and approved in 1947. This legislation provided that a bonus of $100 per month be added to the salaries of all commissioned officers in the medical corps of the federal government.

Because of the need for a balance between the salary scales of medical officers and those of other officers, there was little prospect of materially influencing the procurement picture through further monetary adjustments. But it was clear to the surgeon general that the medical department had to be more

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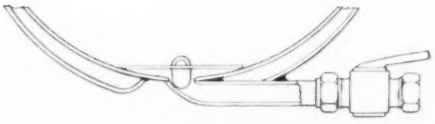

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CITY_____ STATE_____

attractive in order to obtain the additional required numbers of doctors. Substantially blocked on the pecuniary approach, the surgeon general concentrated on the development of an ambitious professional program. Army policy was changed so that a doctor would not be required to be competent in all branches of medicine (or to practice in all fields irrespective of his competence) but rather to establish a high degree of specialization within one branch of medicine.

Although army hospitals have long had an internship program, the establishment of a residency program in the larger general hospitals was an important postwar innovation. Opportunities were now to be given to the abler members of the corps to pursue residency training up to the point where they could qualify for the examinations of the various specialty boards. A further step was the establishment of a career planning unit in the surgeon general's office which was charged with responsibility of ensuring that men would be assigned in accordance with their desires and training. In the prewar period, there was a considerable shifting of men back and forth between professional and administrative assignments. To enhance the attractiveness of an army medical career, prospective members of the corps were advised that they would be able to practice their specialty. For the first time in the army's history the policy was established that an officer promoted to the grade of brigadier general could continue in professional work.

In establishing a residency program, the army provided that an officer commit himself to serve one year for each year of training. By this provision, the army had the services of the officer not only during his residency but beyond. It is anticipated that a high percentage of these residents will eventually elect to remain permanently in the army.

FURTHER STEPS TAKEN

Toward the end of 1948 when it became clear to the army that neither the $100 monthly salary bonus nor the residency program in army hospitals and career planning was sufficient procurement lure to build up the regular corps to its basic postwar strength of 3000, further steps were taken to enhance the attractiveness of the medical department. Through the cooperation of civilian medicine, the army was able to preempt a considerable number of residencies in civilian hospitals. By commissioning civilian residents and placing them in the reserve, the army has been able to pay them during the period of their residency and in return can look forward to having them serve on active duty when their training has been completed on the basis of a year's service for a year's training. It is presumed that perhaps as many as 50 per cent of these residents will remain in the army.

As a further step, the army increased the number of internships in its own hospitals and, further, followed a procedure for civilian interns similar to the program for civilian residents, with the exception that it will require two years of active duty for the civilian intern beginning July 1, 1949. On the basis of its experience, the army hopes to be able to retain permanently perhaps as many as 70 per cent of the intern group.

There is little doubt that through these training programs the army will succeed in increasing its regular corps to 3000 within the next several years.

It is therefore well on the way to resolving its long-time personnel problem. It is facing more difficulties in meeting its responsibilities during the interim period, although it is now reasonably certain that it will surmount these difficulties without the need of such extraordinary measures as the draft.

The army is relying on several important interim measures. To counteract the shortage of specialists in the European and Pacific Theaters, the surgeon general is sending teams of distinguished civilian consultants on tours of duty of four to six weeks. In the United States the army is hiring a considerable number of civilians on a full-time and part-time basis. It is endeavoring to have a large number of its 15,000 reserve officers assume on a part-time basis responsibility for some portion of the total work load. It has introduced administrative changes to conserve professional personnel by substituting wherever possible medical administrative officers for doctors; by placing smaller hospitals on a dispensary basis and providing hospitalization for soldiers based at small camps at more distant stations, and by utilizing the facilities of the Veterans Administration and the navy when the opportunity offers.

REMARKABLE ADVANCES SHOWN

Comparisons are usually difficult and frequently dangerous. Nevertheless, it seems reasonable to contend that the federal medical services, especially those of the Veterans Administration and the army, have shown the most remarkable advances over their prior level of performance within the short period since the end of the war. But one can go farther and contend that the quality of medicine, particularly the quality of hospital care, provided in these federal hospitals compares most favorably with that available in civilian life and probably is excelled only in the best university hospitals.

Advances of such magnitude could not have come about except through a redistribution of national medical resources. The implications of this redistribution and the crystallization of a comprehensive medical plan for the federal government must still be assessed before a balanced judgment can be rendered.

This is the second in a series of articles on Federal Hospitalization. The first appeared in the April 1949 issue of The MODERN HOSPITAL. The third article will be presented in an early issue.

How to Reduce Food Costs

(*Continued From Page* 104.)

higher than the actual count. When such inflated figures are used, it is no wonder that food cost per meal as shown in the reports is considerably below actual cost.

CASH DISCOUNTS

If the cash position permits, many dollars per year can be saved through taking advantage of cash discounts. Sometimes failure to take discounts within the ten-day period usually allowed is merely due to red tape. For example, in one hospital we found that all bills were sent to the dietary department for checking, and often held there long after the discount period had elapsed.

By having duplicate receiving slips sent to the accounting office daily, this delay was eliminated.

DIETARY LABOR

Thus far we have talked about raw food cost, but there are ample opportunities for savings in dietary labor in most hospitals. Furthermore, the quality of the personnel employed has a direct bearing on the economy of the whole operation.

Many dietary departments are overstaffed with low paid, incompetent workers. There are often too many part-time workers. Actually, the work could be accomplished with fewer employes but of higher caliber.

By careful study, employing the principles of work simplification, changes can be made in kitchen arrangements and in job routines that will speed the flow of materials and eliminate waste motions. This in turn saves labor and tends to lessen food waste. Do not forget that every worker on the pay roll has to be fed.

COOPERATION

Food is expensive these days. It should not be wasted. This should be understood by every member of the hospital staff—employes, nurses and doctors. Elimination of food waste requires wholehearted cooperation on the part of everyone connected with the institution. This can be brought about through word of mouth and printed messages to individuals and groups. It must be followed up through proper supervision.

NEWS DIGEST

A.H.A. Insurance Study Called "Confusing" . . . Infant Deaths Caused by Aniline Dye in Diapers . . . Incidence of Polio "Alarming": N.F.I.P. . . . Public Health Service Reorganized . . . Patients Safe in Hospital Fire

"Misleading and Confusing" Is Reply to A.H.A. Insurance Committee Survey

CHICAGO.—Only 12.8 per cent of the total insurance premiums paid by hospitals for fire, public liability and malpractice insurance was returned in paid claims, according to a survey just completed by the American Hospital Association. The survey was conducted by the association's committee on insurance for hospitals.

Commenting on the report, insurance executives said the figures were "misleading and would cause confusion" because they are not representative of the insurance experience of hospitals generally.

Replies from 1596 hospitals showed that premiums paid for fire insurance amounted to $6,803,120 of which $940,894 (13.8 per cent) was paid in claims. In the section of the survey dealing with public liability and malpractice insurance, 1628 hospitals reported premium payments of $2,675,105 for public liability insurance of which $210,136 (8.0 per cent) was returned in claims; $1,786,015 was paid in premiums for malpractice insurance, and $279,900 (16.6 per cent) was returned in payment of claims. The total of premiums paid by the hospitals for the three types of insurance protection was $11,264,240; insurance companies paid back a total of $1,430,930, or 12.8 per cent, in settlement of claims.

Ritz E. Heerman, administrator of the California Hospital, Los Angeles, was chairman of the insurance committee. "In addition to these figures," Mr. Heerman explained, "the insurance companies have direct expenses in settlement of claims which are probably a considerable amount, particularly on public liability and malpractice insurance, where legal and court expenses are involved in a large number of cases. On the whole, however, it can be stated from the figures which we have secured that insurance rates for hospitals are not entirely equitable on the basis of experience."

Asked for his comments, one insurance official told The MODERN HOSPITAL that "any legitimate company would automatically reduce the rate on risks showing such loss ratios." Not questioning that the A.H.A. had accurately reported figures obtained from hospitals, he explained that many hospitals may not have had complete records of premiums and losses paid but may have answered the survey questionnaire without obtaining figures from their insurance carriers.

"Furthermore," it was added, "hospitals having large liability losses, especially under malpractice coverage, would naturally tend to ignore the questionnaire rather than submit answers that might be interpreted as reflecting on the institution. Thus the selection of replies would weight the survey toward disproportionately low loss ratios."

The replies represented approximately 42 per cent of hospitals questioned, the report indicated.

Mr. Heerman said the committee plans to work with insurance companies and bureaus representing them to interest them in setting up a rating bureau for malpractice and public liability insurance in hospitals; to develop standard rates for these types of insurance; to enlist their cooperation in compiling experiences with the American Hospital Association, and to develop a safety program that will ensure the interest of all hospital administrators in carrying out standardization of procedures and regulations. The committee will also work with the insurance companies to develop improved uniform standards of inspection and reports, it was added.

The committee is "mindful of the fact that the main concern of hospitals is patient care," the report concluded. "We should leave insurance to the insurance field if it will cooperate with hospitals in developing a sound and economical program. It is in the public interest that any excessive costs which may be reflected in charges to patients be curtailed."

Members of the committee are: Sister Elise, Sisters of Charity, Mount St. Joseph, Ohio; Frank S. Groner, Baptist Hospital, Memphis, Tenn.; Gerhard Hartman, State University Hospitals, Iowa City, Iowa; Charles A. Lindquist, Sherman Hospital, Elgin, Ill., and Ronald Yaw, Blodgett Memorial Hospital, Grand Rapids, Mich.

Middle Atlantic Assembly Members Vote to Continue Annual Conferences

TRENTON, N.J.—State hospital associations of New Jersey, New York and Pennsylvania have decided to continue the yearly meetings of the Middle Atlantic Hospital Assembly, it was announced here last month following a poll of the associations' memberships.

The 1950 meeting of the assembly will be held at Buffalo, N.Y., May 24, 25 and 26, and the 1951 meeting will be held at Atlantic City, May 23, 24 and 25, the announcement said.

Assembly officers for 1949-50 are: president, Moir P. Tanner of New York, succeeding George H. Buck of New Jersey; vice president, Robert W. Gloman of Pennsylvania; treasurer, John F. Worman of Pennsylvania, and secretary, J. Harold Johnston of New Jersey.

NEWS...

Deaths of Four Infants Attributed to Absorption of Aniline Dye on Diapers

LAKE WALES, FLA.—The death of four babies in the Lake Wales Hospital here last month was believed to have been caused by methemoglobinemia due to absorption of aniline dye on diapers. While final diagnosis awaited necropsy results, Miss Bree Kelly, hospital administrator, said the diaper dye was apparently responsible.

Ordinarily when such dyes are used by commercial laundries the diapers are boiled after marking; this fixes the dye and absorption may not occur. In this case it is suspected that the diapers were sterilized after they were marked with the dye, hospital officials reported, but not boiled or washed out to remove the oil through which the dye is absorbed.

By a strange coincidence, the illness and death of the Lake Wales infants was reported during the same week that the *Journal of the American Medical Association* appeared with an article by Dr. B. M. Kagan and a group of associates warning against the hazard of aniline intoxication from diapers stamped with inks containing aniline dyes. Dr. Kagan and his associates reported on nine cases in which aniline was absorbed through the skin converting hemoglobin to methemoglobin, a nonoxygen carrying pigment.

"Infants, especially premature infants, are particularly susceptible to diminished supply of oxygen and hence even slight degrees of methemoglobinemia may be serious," the article said.

Prevention of such accidents is simple. If the diapers are boiled after they are stamped and thoroughly dried before use, the dye becomes fixed and absorption does not occur. The ideal method of prevention would be the use of nontoxic dyes, but unfortunately, vegetable pigments, charcoal and silver nitrate lack the permanence required for marking clothing in large institutions."

Directors of the hospital have asked appropriate local authorities to conduct a complete investigation of the Lake Wales deaths in order that all facts may be known and made public, a release from the hospital stated. As soon as the infants' symptoms were noticed, it was reported, hospital authorities and staff members called pediatric specialists in consultation and a tentative diagnosis of aniline poisoning was made.

Dedicates Outpatient Wing

NEW YORK.—A newly constructed emergency and outpatient wing at the Roosevelt Hospital was opened here last month with dedication ceremonies featuring talks by Dr. Marcus D. Kogel, New York commissioner of hospitals, and Police Commissioner William O'Brien. The new building will be called the James I. Russell Memorial; it is named for the late Dr. Russell who was a member of the hospital's surgical staff for 40 years. The new building was erected at a cost of $630,000 it was reported and includes facilities for emergency treatment of an estimated 10,000 patients a year.

Dedication of new outpatient wing.

Negro Hospital Recognized

NEW YORK.—The New York State Department of Social Welfare has recognized the Mount Morris Park Hospital as a voluntary institution, making the 55 bed hospital, recently converted from proprietary operation, the first institution founded by Negroes to attain full voluntary status in the state, Dr. C. Marquez, president, said. The hospital will be operated by a lay board of trustees with interracial membership.

Given Remington Medal

WASHINGTON, D.C.—Ernest Little, professor of chemistry and former dean of Rutgers College of Pharmacy, has been given the Remington Medal of the American Pharmaceutical Association, it was announced at association headquarters here last month. The award was conferred in recognition of Dr. Little's "tireless efforts on behalf of pharmaceutical education."

Gives $133,000 for Physical Medicine Unit

DALLAS, TEX.—Grady H. Vaughn, president of the G. H. Vaughn Production Company, a Dallas civic leader, has made a gift of $133,000 to Baylor Hospital to construct and equip a department of physical medicine, Lawrence Payne, hospital director, announced here last month. Mr. Vaughn, who is undergoing physical therapy treatments at Baylor in an effort to recover from two paralytic strokes suffered in 1947, said that he owed his life to physical therapy.

Mr. Payne (left) accepts check from Grady H. Vaughn, Texas philanthropist.

"I believe in physical therapy," the philanthropist said. "I believe it is one of the finest developments in the medical profession in recent years, and I want to see other people benefit from it."

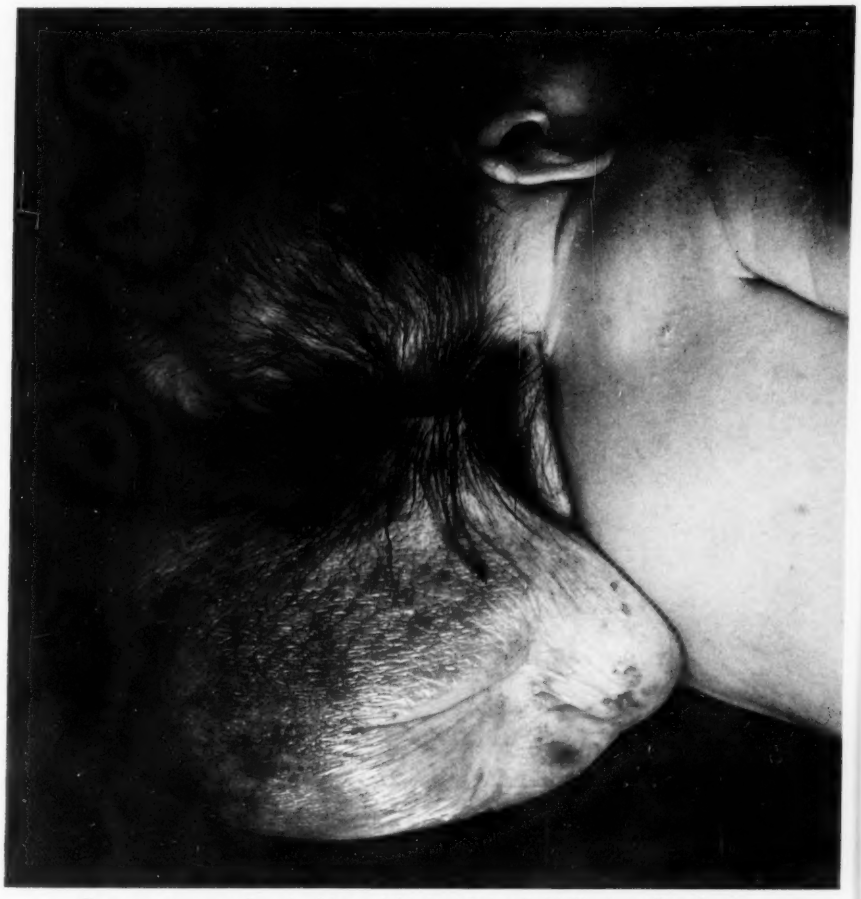
The new department will be located on the first floor of Baylor's new Truett Memorial Hospital Building between the west wing and the present building, Mr. Payne said. Cost of the Truett Memorial Building is estimated at $5,500,000.

230 Patients Moved to Safety in Evansville Hospital Fire

EVANSVILLE, IND.—Removal of 230 out of 250 patients at the Deaconess Hospital here was reported last month following a fire and explosion in a surgery section on the fourth floor. Patients remaining in the hospital were in a section unaffected by fire or smoke, according to Associated Press reports.

Newspaper stories of the fire said that evacuation of patients without incident or loss was attributed to "a quick thinking hospital staff following a fire escape plan strengthened after the recent disastrous hospital fire at Effingham, Ill."

Picture the patient's progress



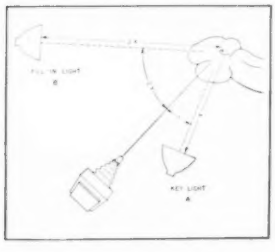
ENCEPHALOCYSTOCELE: *Reproduced from a 4x5-inch original on Kodak Ektachrome Film, Type B.*

...with photograph...after photograph

MAKE PHOTOGRAPHY THE RULE . . . that's the answer. Take plenty of photographs of each case. No telling when such records may be all-important . . . a means of presenting vital information quickly, powerfully . . . a way of settling questions of fact or opinion.

Consider, for example, the color photograph shown above . . . the frames from the surgical motion picture shown below . . . the transparencies on the page following. See how accurately they tell their stories . . . how completely, how convincingly, how lastingly.

TRANSURETHRAL SURGERY: *Three frames from a 16-millimeter Kodachrome motion picture.*



Light A, slightly below camera level, provides chief modeling illumination. Shadows are filled in with illumination from light B placed higher than camera and at distance indicated.

Serving medical progress through Photography and Radiography

Kodak
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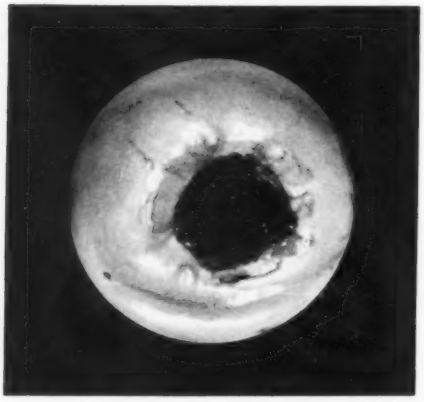
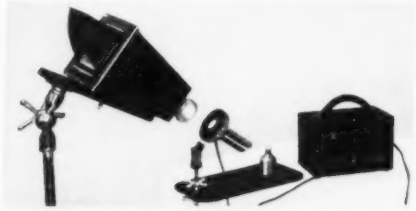
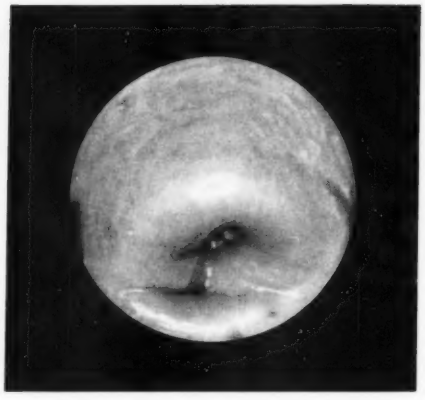
Picture the patient's progress (*continued*)



CANCER, UTERINE CERVIX: *Typical routine photographs of uterine cervix from a case showing progress during treatment for cancer. Upper left photograph shows lesion at first examination—lower right portrays healed condition. Reproductions are same size from Kodachrome transparencies made at 1:1 scale.*

PHOTOGRAPHY OF THE UTERINE CERVIX: *Complete setup, designed for this technic, consisting of adjustable stand, camera, lighting unit, speculum, mount, and electrical control box.*





Most cameras become "color cameras"

. . . when they're loaded with Kodak color film

16-millimeter motion-picture cameras use Kodachrome Film in rolls or magazines . . . give duplicates for brilliant showings.

Yes, getting brilliant color is a simple matter with full-color Kodak Film—Kodachrome or Ektachrome. No special equipment . . . no special technic is required for exposure.

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Miniature cameras, most of them, use Kodachrome Film . . . give slides for projection, prints, enlargements.

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***Sheet-film** cameras take **Kodachrome Professional** and **Kodak Ektachrome Films** . . . give full-color transparencies, prints, enlargements.*

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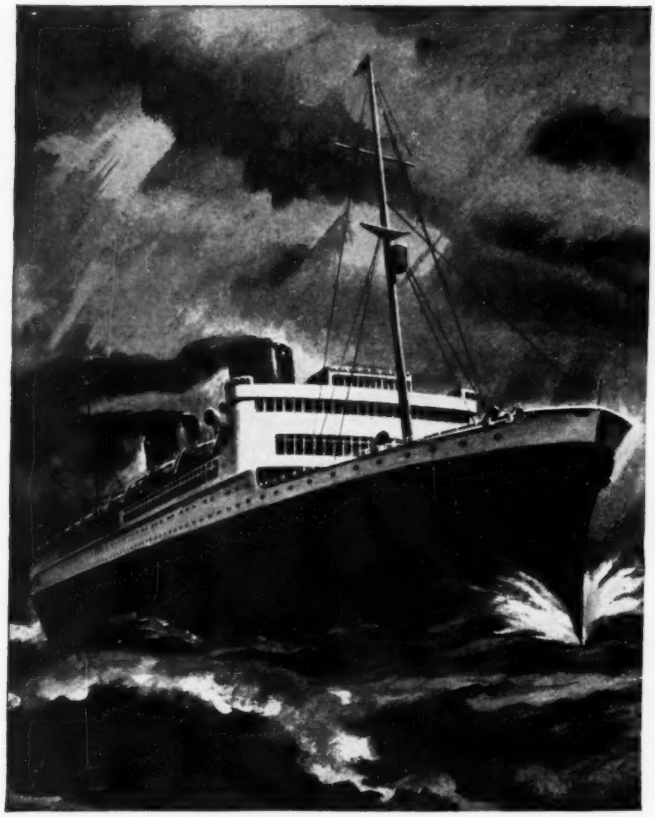

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to Assure That Extra Margin of Safety...

For weathering stormy postoperative conditions which may act as causal factors in wound disruption—you can count on the "holding power" of CURITY Catgut Sutures.

This advantage is every bit as important during wound healing as it is when you tie the knot! Not only does CURITY Catgut provide more than adequate tensile strength—but all-round *Balanced Quality* to assure that *extra margin of safety*.

For the suture that will come through with flying colors despite severe strains imposed upon it . . . specify CURITY Catgut.

Curity Balanced Quality assures proper suture function

- adequate tensile strength
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NEWS...

Scheele Announces Sweeping Reorganization of Public Health Service


Dr. J. R. McGibony


Dr. Vane Hoge

WASHINGTON, D.C.—In a sweeping reorganization of the Public Health Service announced here last month by Surgeon General Leonard A. Scheele, Dr. Vane Hoge, formerly chief of the Division of Hospital Facilities, became associate chief of the Bureau of Medical Services, one of four major areas under which all activities are now grouped. Dr. John R. McGibony, formerly Dr. Hoge's assistant, was made chief of the newly organized Division of Medical and Hospital Resources.

Dr. John W. Cronin was named by the Surgeon General to succeed Dr. Hoge as chief of the Hospital Facilities Division, which administers the national hospital survey and construction program under the Hill-Burton Act. Dr. Cronin was previously in charge of the Division of Federal Employe Health.

In further changes announced at the same time, Dr. Joseph O. Dean was appointed associate chief of the Bureau of State Services, Margaret Arnstein was made chief of the Division of Nursing Resources, and Dr. G. Halsey Hunt became chief of the Division of Hospitals, which operates the Marine hospital system.

Dr. Hoge and Dr. McGibony have been at the head of the Hospital Facilities Division since the inauguration of the program and are familiar to hospital people throughout the country as speakers at hospital meetings and contributors to hospital literature. Dr. Cronin is a graduate of the University of Cincinnati College of Medicine; he has been a member of the Public Health Service staff since 1943. A graduate of Columbia University College of Physicians and Surgeons, Dr. Hunt has been in the Public Health Service since 1936.

Miss Arnstein, formerly assistant chief of the Division of Nursing, is a graduate of the Presbyterian Hospital School of Nursing, New York. She served in staff and executive positions with several county and state public health departments before joining the Public Health Service in 1941. During the war she served as chief nurse of the Balkan Mission of U.N.R.R.A.

Incidence of Polio Cases Alarms Foundation Officials

NEW YORK.—The nationwide incidence of poliomyelitis was described as "disturbing if not alarming" by the National Foundation for Infantile Paralysis here last month. At a meeting of foundation chapter chairmen, Basil O'Connor, president, said that if the present increase over 1948 in the number of cases continued it might be necessary for the foundation to put on a special "disaster drive" for funds in August or September.

California and Texas were described by Mr. O'Connor as the principal danger spots on the basis of early incidence reports. Other sections of the country where indications are unfavorable include New England, Florida, the South and Southwest, Mississippi Valley and state of Washington, it was added.

Total number of cases reported were in excess of 2700 on July 1, it was explained, compared to approximately 2000 for the same period in 1948. The situation in New England has reached "alarming proportions," Dr. Hart E. Van Riper, medical director of the foundation, stated. "If it does not level off in California and Texas, which were hard hit last year, it will be a calamity," the medical director added.

Southeastern Hospital Pharmacists to Meet

NEW ORLEANS.—The semiannual conference of the Southeastern Society of Hospital Pharmacists will be held here October 15 and 16, it was announced by Albert P. Lauve, chief pharmacist of New Orleans Mercy Hospital and president of the regional group, which includes members from West Virginia, North and South Carolina, Kentucky, Tennessee, Georgia, Alabama, Florida, Mississippi and Louisiana.

A single protein preparation to take the place of meat. At a time when the patient's protein needs are the greatest, that protein supplement *must* be adequate.

With this aim in view, Abbott scientists painstakingly tested all possible source materials. They narrowed their choice to animal blood fibrin, one of the highest biologic value proteins. They hydrolyzed it to conserve all the amino acids in the correct pattern for optimum tissue repletion. The result: AMINOSOL.

FOR MEAT I.V.

Every known laboratory test is performed to assure AMINOSOL'S ability to promote and maintain growth, its sterility and its freedom from antigenicity. But the greatest test of all comes in clinical usage. Here it has been shown that as the sole source of amino acids, 2000 cc. of AMINOSOL daily will maintain nitrogen balance in a 70-Kg. man until the time when whole meat may again take its place in the diet.

AMINOSOL is supplied in 500-cc. and 1000-cc. Abbott Intravenous Solution Containers, ready to use. It may be stored at ordinary room temperatures for two years or longer. Next time, specify AMINOSOL. ABBOTT LABORATORIES, North Chicago, Illinois.

AMINOSOL®

(ABBOTT'S MODIFIED FIBRIN HYDROLYSATE)

5% Solution

5% with Dextrose 5%

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For convenient administration

USE VENOPAK*

Abbott's completely sterile and disposable venoclysis unit. Safe, convenient — ready to be used once, then throw away.

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NEWS...

Recommend Plumbing Standards; Salad Oil Packaging Approved

WASHINGTON, D.C.—A recommended revision of staple vitreous china plumbing fixtures, commercial standard CS20-47, has been submitted to producers, distributors and users for acceptance, according to an announcement of the commodity standards division, National Bureau of Standards. Proposed by the Vitreous China Plumbing Fixtures Association, the recommended revision brings the standard into line with present commercial practices as to weight of closet bowls, thickness of ware and standard dimensions of tanks, juvenile bowls, bowls for flush valve operation, and faucet-hole spacing for exposed center-set fittings mounted horizontally. Other modifications are included for better arrangement and other improvements, it was explained. The greater part of the present standard is not modified, however, and the material circulated covers only recommended changes.

Copies of Simplified Practice Recommendation R193-49, Packages for Shortening, Salad Oil and Cooking Oil, are now available, according to another announcement by the division. The recommendation was originally issued in 1942, and was recently revised to substitute a 50 pound package for the 48 pound size for shortening. Also, 4, 6 and 8 pound packages have been dropped as standard package sizes for shortening and a 24 package shipping case for the 1 pound package has been included. The ½ gallon size of package for salad and cooking oil has also been dropped from the list of standard stock sizes. The revised simplified practice recommendation is effective as of June 15, 1949, for new production.

Auxiliary Secretary Appointed

CHICAGO.—Mrs. Corena McCallum has been appointed secretary of the American Hospital Association's newly formed committee on women's hospital auxiliaries, it was announced here last month by George Bugbee, executive director. Mrs. McCallum was formerly director of public relations for the Illinois State Nurses' Association. The appointment was described by Mr. Bugbee as "a step forward in the hospital auxiliary movement through the exchange of information and ideas."

V.A. to Acquire Site for Hospital in Atlanta, Ga.

WASHINGTON, D.C.—Final action to acquire a site for a 500 bed general medical and surgical hospital in Atlanta, Ga., has been initiated, Carl R. Gray Jr., veterans administrator, announced here last month. The new hospital will be constructed on the Asa G. Candler Jr. estate, a tract of approximately 42 acres. The site is about one and one-half miles west of Emory University Hospital and about four miles northeast of the center of the city.

The dean's committee of Emory University Medical School will cooperate with V.A. in staffing the hospital, it was explained, assuring the highest type of medical care for sick and disabled veterans.

Your Guide to Modern Hospital Planning

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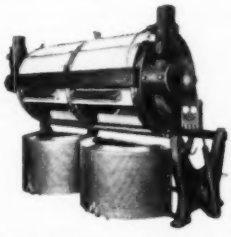
Detailed Equipment Needs
Operating Data...
For Small, Medium and Big Hospitals...



UNLOADING "SILVER CREST"

Cuts down pulling time and labor costs – cylinder raises hydraulically to deposit loads into extractor basket halves. Faster operation – more loads per day – saves floor space.

As part of its advisory service to hospital administrators, architects and engineers, Hoffman offers this practical guide to modern laundry planning. All phases of laundry operation are discussed in this comprehensive work. Operating data, floor dimensions and specific recommendations for laundries in hospitals of 25 to 200 beds are presented in detail.

If you are confronted with the problem of modernizing existing institutional laundry facilities, or planning a new layout, "Planning the Hospital Laundry" contains information you want. A request, on your letterhead, will bring you a copy without obligation.

Free Survey

Hoffman laundry engineers will analyze your laundry operating costs; survey your linen requirements and suggest control schedules; furnish new layout plans; and recommend equipment to help you save floor space, time and labor, fuel, supplies and linen.

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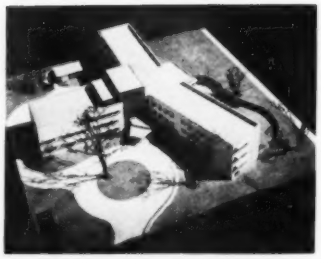
COMPLETE LAUNDRY EQUIPMENT SERVICE FOR THE INSTITUTION

NEWS...

Michael Reese Constructs Psychosomatic and Psychiatric Research Unit

CHICAGO.—Construction of a $1,850,000 institute for psychosomatic and psychiatric research and training was undertaken here last month at Michael Reese Hospital, Dr. Morris H. Kreeger, hospital director, announced. The institute will be the second major hospital building to be constructed in the long-range medical center plan of Michael Reese, Dr. Kreeger stated. A $500,000 laundry service building is nearing completion. It is expected that the institute building will be finished late in 1950. Scheduled for early construction are a private pavilion for medical and surgical patients and a convalescent hospital, Dr. Kreeger said.

The institute has been set up and functioning at Michael Reese since 1946 under the direction of Dr. Roy R. Grinker, it was explained. During this time, while planning the new structure, the institute has been without separate building facilities. The building, which has been planned since 1945, is the result of years of study by architects, psychiatrists and hospital consultants. Architects are Loebl, Schlossman and Bennett.



Architect's model of psychiatric unit.

"Our general purpose," Dr. Grinker stated, "is to have a facility in which the problem of the emotionally disturbed patient, with or without physical symptoms, should be studied and treated with the concept that both his mind and body constitute an inseparable unit which requires the cooperation of many specialists, and that this concept is a central point of teaching not only psychiatrists, but all other medical men. Our research program will be supported by a fund created by the A. D. Lasker family and supplemented by private donors and government subsidies.

"There will be facilities for research, teaching and care of patients. About 20 per cent of the space has been set aside for research. This includes laboratories, not directly connected with the patient, such as the biochemistry and physiology laboratories and the research facilities that have to do with patients—electroencephalographic facilities, physiological testing, and large laboratories for psychology.

"One of the prime purposes at the institute will be the teaching of much needed trained personnel: resident physicians training to become psychiatrists; medical students, social workers, nurses, occupational therapists, psychologists, ministers, and interns, residents, and staff doctors in other specialties on the Michael Reese staff. Large seminar and conference rooms have been provided. There will be an amphitheater seating 125, a library and nurses' classrooms on each floor.

"Seventy per cent of the space has been devoted to patients," Dr. Grinker continued. "Although the divisions are flexible, this space has been divided into four sections. The psychosomatic

NEWS...

section, which has 32 beds, will deal with physical disturbances in which a large element of the cause of the disturbance itself is emotional. This includes such conditions as dyspepsia, ulcer, diarrhea, colitis, asthma, headaches, diabetes and arthritis. Since these are not just pure mental and emotional disorders, but medical problems that confront every doctor daily, the patients on this floor will be cared for comprehensively by both internists and psychiatrists in cooperation.

"One entire floor will be devoted to the psychiatric section. There we will hospitalize people who are directly emotionally upset with anxieties and depressions and who need care outside of their home environment. By setting up such a unit we will save them from the highly expensive private sanitariums, or for the less well off, from the overcrowded public mental institutions. They will get the best facilities, good psychiatric care, and all the necessary medical auxiliary services on the principle that the psychiatric patient should be hospitalized where he can be given such facilities and personnel for thorough study and treatment of body and mind, and where he will find a cheerful and hopeful environment suggestive of all that is familiar in a good hospital atmosphere."

Anesthetists to Discuss Medical Problems at A.H.A.

CHICAGO.—Emphasis will be placed on medical problems related to anesthesia at the sixteenth annual meeting of the American Association of Nurse Anesthetists in Cleveland's public auditorium September 26-29, it was announced at association headquarters here last month. A forum on this subject is to be conducted by Donald Hale, M.D., anesthesiologist at the Cleveland Clinic, with members of the clinic staff participating. An entire morning will be devoted to clinics at Cleveland City Hospital, the University Hospitals and the Cleveland Clinic Hospital, the announcement said.

Dr. Carl H. Lenhart, chief of surgery at the University Hospitals of Cleveland, whose school of anesthesia was the first formally organized course for training nurse anesthetists, will be given the association's award of appreciation, given annually to a person or institution that has made an outstanding contribution to the advance of nurse anesthetists.

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More proof—that this outstanding disinfectant value gives *quality* performance at a *quantity* price!

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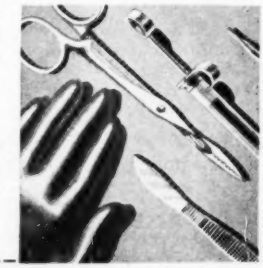
Potent—Effective! Completely safe and sure for the disinfection of dishes and utensils used by patients with contagious diseases.

Non-corrosive! O-syl guards expensive instruments from rust, safely and surely disinfects rubber goods.

Non-Specific! Eliminates the necessity of keeping several germicides for various specific purposes.



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O-syl

Professional sample upon request. Call your hospital supply dealer or write direct to: Lehn and Fink Products Corp., Hospital Dept., 445 Park Ave., New York 22, N. Y.

NEWS...

Oppose Efforts to Curtail Expansion of V.A. Hospitals

WASHINGTON, D.C.—Continued opposition to the American Hospital Associaton-Hoover Commission efforts to curtail the Veterans Administration's hospital construction program was expressed here last month. Elaborating on an earlier statement, Gen. Jonathan Wainwright said that "powerful organizations are working to retard the accepted program authorized by Congress."

The reorganization recommendation of the Hoover Commission threatens hospital facilities for thousands of war veterans, Carl Gray Jr., veterans administrator, said in a letter to Rep. John Rankin, chairman of the Veterans Committee of the House of Representatives. The recommendation runs counter to the government's policy of treating veterans as a class deserving special consideration, Mr. Gray's letter stated. He criticized the Hoover Commission-A.H.A. criticism of hospitalization for veterans for nonservice connected disabilities.

Oscar Ewing, federal security administrator, stated in a letter that he was opposed to the Hoover Commission's recommendation that the Public Health Service be transferred from the Federal Security Administration to a United Medical Administration.

Oklahoma, Kansas Seek Ways to Combat Doctor Shortage

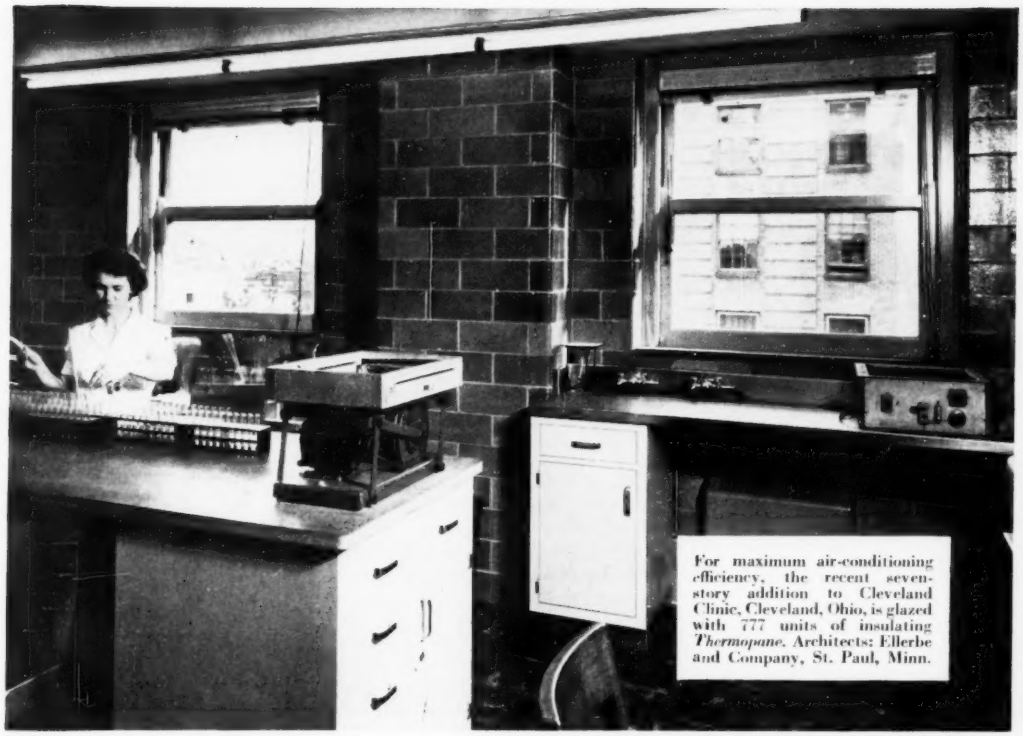
KANSAS CITY, KAN.—Efforts to combat the shortage of general practitioners in rural Kansas have been undertaken at the University of Kansas Medical School here, according to reports published last month. Dr. Franklin D. Murphy, dean of the medical school, said the state legislature had approved an appropriation permitting immediate expansion of the school's facilities. In addition, communities lacking physicians have been encouraged to levy taxes or sell bonds to raise funds which may be used to provide office equipment or subsidies for young physicians to attract them to local practice. The program has the approval of the State Board of Health which is acting as a clearing house of information between communities needing doctors and doctors in search of practice, it was reported.

Another plan to interest young physicians in rural practice was reported at Oklahoma City where Dr. Mark Everett, dean of the medical school at the University of Oklahoma, outlined a preceptorship plan under which medical students spend three months a year as apprentices to experienced rural general practitioners. Another phase of the Oklahoma plan provides for the establishment of regional general practice internships in community hospitals throughout the state, it was explained.

Council Executives Meet

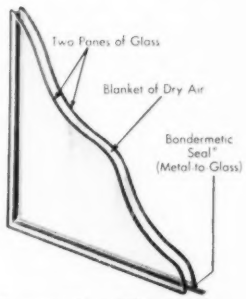
PHILADELPHIA.—The first meeting of full-time hospital council executives was held here last month. E. E. Salisbury, executive secretary of the Chicago Hospital Council, said the group, which also includes secretaries of state hospital associations, would meet regularly hereafter at the time of the American Hospital Association convention and at one other time during the year.

"We have so many problems and projects in common that such meetings cannot fail to be constructive," Mr. Salisbury stated.



For maximum air-conditioning efficiency, the recent seven-story addition to Cleveland Clinic, Cleveland, Ohio, is glazed with 777 units of insulating *Thermopane*. Architects: Ellerbe and Company, St. Paul, Minn.

Better Indoor Climate Control with *Thermopane*...



Cutaway view of *Thermopane*

With *Thermopane** windows, hospitals solve a big problem in controlled indoor temperatures and humidities.

Installed in fixed or opening sash, this sealed double-glass windowpane helps keep rooms cooler in summer. In winter, it cuts heat loss, reduces downdrafts, saves fuel. Heating and air-conditioning systems function more efficiently.

In rooms where high humidities are required, *Thermopane* minimizes condensation on glass. Where quiet must be maintained, *Thermopane* deadens sound.

Many hospitals are glazed throughout with *Thermopane*. Others use it to help maintain required conditions in operating rooms, nurseries, laboratories and other special-purpose rooms. For full details, write for our *Thermopane* book and list of standard sizes.

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NEWS...

Community Hospital Nurses to Affiliate With University of Buffalo

WARSAW, N.Y.—An agreement with the University of Buffalo which will provide a nine-month college course for each student nurse enrolled at the Wyoming County Community Hospital School of Nursing was completed here last month, according to a hospital announcement. The plan will go into effect with the class entering next September, it was explained.

"We believe that our plan of university affiliation not only will provide an excellent foundation in the sciences for our nursing students," said Mary H. Griffiths, director of the community hospital school, "but also will contribute to the cultural development and maturity so essential to the successful nurse."

During the first nine months of the three-year school of nursing course, students will spend four days each week attending classes at the university and living in the residence of the Children's Hospital, Buffalo. The rest of the week, at Warsaw, will be given over to beginning instruction in nursing arts and free time, it was explained.

Cost to the student for the three-year period has been established at $350, which is paid by installments. It has been estimated that the school year at the university would cost the student's family nearly $1000 if the student were privately enrolled, Miss Griffiths said.

Council Elects Officers

BROOKLYN, N.Y.—Fred K. Fish, superintendent of the Lutheran Hospital, was elected president of the Hospital Council of Brooklyn at a meeting here last month. Other officers elected were: vice president, H. F. Rudiger; secretary-treasurer, Arthur Feigenbaum; members of the executive committee, John J. Kelly, Dr. I. Magelaner, R. A. Carvolth and E. H. Decker.

Brooklyn Hospital Council officers.

"Talc is a Dangerous Agent in its present use as a Surgical Glove Lubricant"[1]

SAFE SUBSTITUTE NOW AVAILABLE AT COST OF ONLY 2¢ PER OPERATION

Postoperative adhesions caused by glove powder have long been a serious concern of surgeons and operating room assistants.

All published studies agree that talc as a glove lubricant is unsafe. Animal experiments have shown the dangerous complications that follow talc implantation.

* * *

EFFECTS IN TISSUE

Talc consists chiefly of magnesium silicate. It causes granulomatous reactions in tissue, resulting in intra-abdominal adhesions, persistent sinus formation, or nodules in the wound.

* * *

"Implantation of glove powder may occur from unwashed gloves, perforations in gloves, spill on to sponges, instruments, and suture material, and by the air-borne route."[1]

* * *

SERIOUS COMPLICATIONS

"The frequency of such contamination is attested by the increasing number of case reports of serious complications due to talc. Animal experiments show that the granulomatous reaction can be regularly produced in the peritoneum, pleura, pericardium, muscle, joint, nerve and tendon."[1]

FOREIGN BODY REACTION

German[2,3] found intra-abdominal granulomata which he proved came from foreign body reaction to talc in 40 out of 50 unselected patients subjected to a second laparotomy.

* * *

Seelig[4,5] repeatedly demonstrated the danger of talc in mice, which are notably resistant to the production of adhesions, by injecting 2cc. of a 5% saline suspension of the powder intraperitoneally, and has stated that "the average surgeon cannot possibly perform this experiment and ever afterward face talcum powder with equanimity."

* * *

REPLACEMENT

As a replacement for talc, a wholly safe and efficient dusting powder is now available. This new powder, called Bio-Sorb, is a mixture of amylose and amylopectin, derived from cornstarch, with a small amount of magnesium oxide added. It is treated physically and chemically to assure good lubrication after sterilizing.

* * *

COMPATIBLE WITH TISSUE

Bio-Sorb is compatible with body tissues and is rapidly absorbed. It does not injure rubber gloves. It fits regular O.R. technics. Costs less than 2 cents per operation. Bio-Sorb has been used over two years in several hundred hospitals. Complete literature mailed on request.

* * *

SAFETY CONFIRMED

The findings of Lee and Lehman[6] that Bio-Sorb is safe have been confirmed by Lindenmuth[7] and MacQuiddy.[8] Postlethwait et al[1] concluded that "talc is a dangerous agent in its present use as a surgical glove lubricant," and stated that "a modified starch powder (Bio-Sorb) which is absorbed with little or no reaction is again suggested as a satisfactory substitute for talc."

* * *

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NEWS...

Air Force Will Have Separate Medical Service

WASHINGTON, D.C.—Organization of a separate medical service for the United States Air Force was announced here last month by Gen. Hoyt S. Vandenberg, chief of staff. Organization of the medical service is in accordance with a directive issued some time ago by Defense Secretary Louis Johnson, the announcement stated.

"The new air force medical service will provide better flexibility and control for air force medical services and requirements," General Vandenberg said, "and will provide more efficient and equitable coordination under unification of control within the national military establishment. No duplication will exist under the new organization since the air force previously had a medical service which was under army control." Maj. Gen. Malcolm C. Grow, surgeon general of the U.S. Air Force, will direct the new service, it was stated.

COMING MEETINGS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Cleveland, Sept. 25-26.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Netherlands Plaza Hotel, Cincinnati, Sept. 6-10.

AMERICAN HOSPITAL ASSOCIATION, Cleveland, Sept. 26-29.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Book-Cadillac Hotel, Detroit, Aug. 23-25. Institute, Aug. 26, 27.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Cleveland, Sept. 23-24.

ASSOCIATION OF CALIFORNIA HOSPITALS, Recreation Center, Santa Barbara, Nov. 17, 18.

KANSAS HOSPITAL ASSOCIATION, Jayhawk and Kansas Hotels, Topeka, Nov. 10, 11.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, duPont Hotel, Wilmington, Del., Nov. 14-15.

NATIONAL SAFETY CONGRESS AND EXPOSITION, Oct. 24-28, Chicago.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Commodore Hotel, New York City, Nov. 7-9.

NEBRASKA HOSPITAL ASSEMBLY, Paxton Hotel, Omaha, Nov. 17, 18.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Hotel Tulsa, Tulsa, Nov. 17, 18.

SOUTHEASTERN SOCIETY OF HOSPITAL PHARMACISTS, New Orleans, Oct. 15, 16.

1950

BOARD OF METHODIST HOSPITALS AND HOMES, Congress Hotel, Chicago, March 1, 2.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, April 12-14.

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, March 22-24.

SOUTHEASTERN HOSPITAL CONFERENCE, April 5-7.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, March 7-9.

Are you faced with the dual problem of finding a *low-salt* diet with high *appetite appeal*? Then try Quaker Puffed Rice and Wheat—the Puffed Grain cereals that give you satisfactory answers on both counts.

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Quaker Puffed Rice and Wheat are both low sodium cereals. *No salt has been added.* Nor have foreign flavorings (including sugar) been added.

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APPETIZING

Appetites dulled by the monotony of restricted diets respond encouragingly to the crisp, wholesome daintiness of Quaker Puffed Grains. And those gay, perky Individual packages on the breakfast tray lend a genuine note of cheerfulness . . . start the patient's day off right.

Try Quaker Puffed Grains on your own menus. Ounce for ounce, they offer you energy values comparable with other ready-to-serve cereals . . . PLUS *a delicious low-salt serving remarkably high in appetite appeal!*

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PUFFED WHEAT AND PUFFED RICE

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NEWS...

Physical Medicine Aids Hemiplegics, V.A. Reports

WASHINGTON, D.C.—A study conducted by the Veterans Administration hospital in Dearborn, Mich., reveals that physical medicine technics frequently can prepare hemiplegic patients, with half their bodies paralyzed, for lives of independence outside the hospital.

The technics, when scientifically and assiduously applied, also lead to total, partial or sheltered employment, the study added.

The hospital has treated 48 hemiplegics since Jan. 1, 1948, applying physical medicine procedures. Of these, 30 were discharged to their homes; two were sent to V.A. domiciliaries, and one was transferred to another V.A. hospital for further rehabilitation.

Twelve of the 33 formerly were confined to their beds and five were wheelchair patients. Now, all are able to walk with varying degrees of proficiency.

Three progressed from complete bed confinement to wheelchair status; 11 were able to take a few steps when they entered the hospital but now can get about more readily, and one entered the hospital as a wheelchair patient and now can walk about 50 yards with the aid of a cane.

Length of treatment averaged 10 weeks, with a range of from one week to 10 months. Duration of the hemiplegic condition before physical medicine technics were undertaken averaged 10 months, with a range of from one month to five years.

The report indicated that the earlier physical medicine rehabilitation procedures are instituted, the better are the results.

Nurses Taught "How to Listen" to Patients' Woes

CLEVELAND.—The art of listening to patients who are emotionally upset because of illness or injury was emphasized in a series of five discussions for practicing professional nurses at Western Reserve University here recently. Sponsored by the school of nursing, the discussions were conducted by Dr. Alfred K. Bochner of the department of psychiatry at the university's school of medicine.

Commenting on the discussions, Dr. Bochner said the art of listening to patients depends on the nurse's understanding of the emotions of both herself and her patient. "There has been a lot of publicity given to mental and emotional illness as such, but there has been a serious neglect of the emotions of the average person who comes to the doctor with other forms of illness," Dr. Bochner said.

"When anyone becomes a patient he is usually emotionally upset. He should be listened to with sympathy and understanding and as much patience as conditions will permit. If a nurse or doctor does not do this he is liable to aggravate emotional distress in the patient." Dr. Bochner said many doctors and nurses are numbed by their heavy burden of work and have a tendency to treat their patients in a routine manner. They give most of their attention to the preparation of records, do most of the talking themselves and fail to listen to what the patient has to say.

"Nurses also should condition their personal attitudes to the needs of indi-

NEWS...

vidual patients," he said. "For example, the nurse who is hasty or overcheerful with a sensitive and depressed patient creates an emotional problem for him. It should not take long for a nurse with the proper understanding to size up a person and decide what attitude will help most."

The discussions were made possible through a grant to the school of nursing by the W. K. Kellogg Foundation of Battle Creek, Mich.

Life Insurance Companies to Contribute $680,000 to Heart Disease Research

NEW YORK.—A total of $680,000 will be contributed by life insurance companies of the United States and Canada during the coming year for the support of heart disease research, it was announced recently by M. Albert Linton, chairman of the Life Insurance Medical Research Fund and president of the Provident Mutual Life Insurance Company of Philadelphia. The awards raise to more than $2,500,000 the amount contributed by the companies since the fund was started late in 1945.

A total of $585,300 of the funds awarded will be used as grants-in-aid by 35 universities and research centers in the United States and Canada for the support of some 53 different research projects being carried on by individuals or by groups of investigators. All of this research is designed to provide basic information about the nature and causes of various forms of heart disease; some represent the continuation of work begun under the fund's support in previous years.

In addition to the money awarded as grants-in-aid, the fund has also announced the allocation of $94,700 for the support of 18 graduate and nine undergraduate research fellows who will work in the field of heart disease under the supervision of experienced investigators in medical centers in this country, in Canada, and, in the case of one award, in Zurich, Switzerland. The Zurich award is the third European fellowship set up by the fund.

Organized late in 1945, the Life Insurance Medical Research Fund is now supported by 147 life insurance companies in the United States and Canada and to date has distributed $2,575,000 for grants-in-aid and fellowships.

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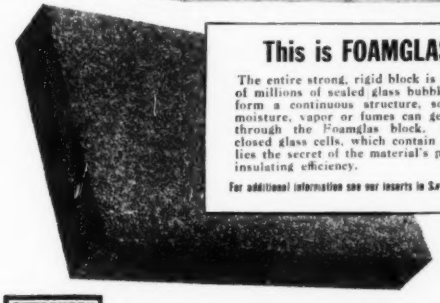

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NEWS...

Propose Revision of Cotton Textile Standards

WASHINGTON, D.C.—Recommendations leading to revision of S.P.R. R74-30 covering hospital and institutional cotton textiles have been proposed by the committee on purchasing, simplification and standardization of the American Hospital Association. The simplified practice recommended has been submitted to producers, distributors, users and other interests for acceptance and/or comments, according to an announcement by the Commodity Standards Division of the National Bureau of Standards.

These recommendations list the standard sizes for various kinds of cotton textiles, such as sheets, pillowcases, pads and towels, used in hospitals and institutions. The current revision provides for changes in the sizes of certain items. A change of major importance is the reduction in width of hems on sheets from 2 inches at each end to 1 inch. The committee is of the opinion that this change will result in longer wear being obtainable when sheets have to be rehemmed owing to damage in laundering.

In addition to these changes, some new items have been added to the simplified schedule. With these changes the recommendation will, in the opinion of the committee, reflect the needs of hospitals and institutions under current conditions and enable all concerned to obtain the benefits of simplified practice.

Copies of the proposed revision can be obtained from the Commodity Standards Division, National Bureau of Standards, Washington 25, D.C.

Patient Stay Decreases, Northwest Report Shows

PORTLAND, ORE.—A statistical report released recently by the Northwest Hospital Service, comprised of 42 Oregon and two Clark County, Washington, hospitals, sponsors of the Blue Cross plan, reflects the increasing efficiency of hospitals and medical science. The report shows a decrease of the length of stay in hospitals in 1948 and indicates the varying causes of hospitalization.

Of the Oregon Blue Cross members for whom 15,455 claims were paid in 1948, more than 85 per cent were hospitalized for 10 days or less; 29.61 per cent stayed one day or less, while only 2.31 per cent required 21 days or more of care. Average stay for all patients of all kinds, including maternity, was six days. In 1947 it was 7.77 days. The shorter stay proportionately reduces the cost of hospital care despite rising prices.

Respiratory diseases and infections led in causes for nonmaternity hospitalization, accounting for 2456 cases, or 25.86 per cent. Digestive disturbances, including appendicitis and hernia, hospitalized 1352, or 14.23 per cent; genito-urinary diseases, 1157, or 12.18 per cent, and injuries, 1639, or 17.26 per cent.

Installs Oxygen Plant

RICHMOND, VA.—The Medical College of Virginia has just completed installation of an oxygen manufacturing plant capable of producing 500,000 cubic feet of oxygen per month, it was announced here last month. The hospital started generating from its plant July 1.

They Do It With People
—why not with Paints?

The Past-Performance Test

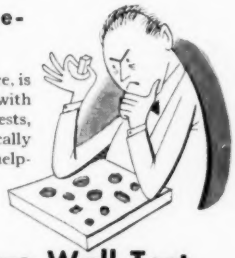
No one ever hires a person without applying the "Past-Performance" test. "What have you done?" . . . "What is your background . . . your education?" . . . "What are your qualifications?" . . . "Where have you worked before?" This, indeed, is good business.

The Say "Ah" Test

Some businessmen have found it wise to use a thorough physical check up to determine the health of prospective workers.

The Square-Peg-in-the-Round-Hole Test

Newer, and of growing significance, is the aptitude test. Not content with past-performance and health tests, businessmen find that scientifically planned aptitude tests are most helpful in finding the *right* man for the *right* job.



The Round-Can-on-the-Square-Wall Test

How many square feet of solid coverage can you get from a round can of paint?

Let's not guess. It is better to test.

Paints, like people, differ greatly. A gallon of one paint will cover more square feet than a gallon of another. Some paints go on faster and easier. Some look better and last longer. So test, brother, test.

Take a gallon of Barreled Sunlight, thin properly, and put it on a wall. See how much it covers . . . how *well* it covers. Check how fast it goes on. Notice how bright and clean it looks after drying. *Then*, do the same with a gallon of any other good paint. Compare the results . . . in terms of coverage, appearance and painting time. You'll see how true it is that Barreled Sunlight will give you a better-looking, longer-lasting interior paint job *for less money* than any other paint on the market.

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NEWS...

New York Hospital Reduces Deficit in Spite of Higher Costs and Increased Load

NEW YORK.—A reduction of $56,506 in its deficit for 1948, in spite of rising costs and increased patient load, was reported by the New York Hospital in its annual report issued recently. During 1948 the hospital treated 77,493 patients, an increase of 1735 over the previous peak year of 1947.

William H. Jackson, president of the board of governors of the Society of the New York Hospital, stated that the figures reflected a loss of $5.78 per patient day. "As has been true for several years," Mr. Jackson reported, "the most pressing internal administrative problems of the hospital were concentrated on costs—both wage scales and materials—and the hourly work week."

A detailed job analysis conducted during the year resulted in an upward revision of the salaries of the majority of the hospital employes in the $25 to $50 a week wage group, he said. In addition to increased salaries in the nursing department, graduate service nurses were put on a 40 hour week but for the transition period a 44 hour week is being worked with the extra hours being paid for on an overtime basis.

The greatest increase in number of patients treated was shown in the outpatient clinics, the report said. These clinics received 285,444 visits during the year. Admission of inpatients also increased despite staff shortages and the closing of three pavilions in October, November and part of December because of the nursing shortage.

Students Name Nursing as First Choice in Careers

BLOOMFIELD, N.J.—Nobody was more surprised than the guidance director when nursing was named as the first choice in careers and teaching as the second choice by 475 members of the junior class of the Bloomfield High School.

Spokesman for the group that favors nursing was 16 year old Jean Schindler, who said: "I want to help people less fortunate than myself."

The strong showing made by teaching was explained by the guidance counselor as the result of a school campaign to stir up interest in that profession.

Fifty per cent of the entire class expects to go to college.

Personnel representatives from various occupations told the students that opportunities for high school graduates are "tightening up" and that "competition is getting tougher every day."

Shortage of Interns Is Serious Problem, New York Council Says

NEW YORK.—The discrepancy of almost 4000 between the number of internships available in the United States and the number of medical graduates is large enough to produce serious dislocations in the operation of many hospitals, the Hospital Council of Greater New York stated in a recent *Bulletin*. Stressing the vital importance of the problem relating to internships, the council stated, "Complete coordination among the hospitals, medical schools, and the approval bodies (of internships) is essential if the internship is to serve the best interest of the interns and the patients."

In New York City as well as for

NEWS...

the country as a whole, teaching hospitals have fared better than nonteaching ones. Of the total number of internships offered in the United States in 1947, 46.8 per cent were in teaching hospitals and 53.2 per cent in nonteaching hospitals. Teaching hospitals reported 8.6 per cent of their positions unfilled, while 32.2 per cent of the positions in the nonteaching group were vacant.

During the last decade there has been a gradual increase in the number of approved internships. From 1938 to 1948 the number of hospitals approved for internship training rose from 729 to 807 (about 11 per cent), with the number of internships listed in these hospitals increasing from 7354 to 9118, or nearly 25 per cent. In contrast to these figures, the number of graduates of medical schools increased only about 7 per cent. Estimates for 1948-1949 indicate a total of approximately 5300 graduates.

DEMAND HAS INCREASED

Quoting the American Medical Association, the *Bulletin* states, "The annual demand for interns has been increased not only by the establishment of additional internships but also by the fact that a much greater proportion of the internships are now offered for a one-year period only. . . . The decline in the number of the longer internships is attributable in part to the fact that more physicians enter residency training after the first year of internship, with a consequent lessening of demand for the two-year plans, and to the fact that some hospitals have been unable as yet to convert from their shorter wartime programs."

The war years made a one-year internship almost mandatory and there has been little evidence of a return to the prewar status. "Even more important than this, however," the *Bulletin* emphasizes, "is the failure of most specialty boards to give credit to the second year of the internship as a part of the specialty training period. Such acceptance would materially increase the number of two-year internships."

The scramble for appointments, on the part of both the student and the hospital, has necessitated repeated modifications of the placement plan by the Association of American Medical Colleges to protect the medical graduate and enable him to select the type of internship providing the best training.

NEWS...

Western Physicians Plan Prepayment Medical Program for Individuals and Families

SALT LAKE CITY, UTAH.—A prepayment medical program open to individuals and families, as well as groups, is being planned by physicians of eight western states. The plan will be ready shortly, in the opinion of Dr. Ray T. Woolsey of this city, who heads the committee.

Stimulated partly by the proposed national health program to be considered by the present Congress, this Western plan grew out of a conference in San Francisco of representatives of the Western Conference of Medical Care Plans.

Medical services now in most states are open to persons on a group basis only. In the eight states, plus British Columbia, Alaska and Hawaii, 2,000,000 are now enrolled. Of these 750,000 are in California, where the California Physicians' Service, sponsored by the California Medical Association, has been operating for ten years.

Dr. Woolsey's committee is studying the possibilities of a regional program which, without interfering with state and county plans, would help them enlarge their membership rolls, partly through bringing in new members on an individual basis. It would also enable the stronger doctor sponsored plans to aid the weaker ones.

ALL HAVE STATEWIDE PLANS

Of the states represented in the regional project, California, Idaho, New Mexico, Montana, Utah and Nevada, all have statewide plans sponsored by their medical societies. Washington has 21 county plans, some of which cover up to four counties. The Oregon plan operates in 32 counties with the other four counties covered by separate county plans.

Hawaii and British Columbia have territory-wide and province-wide plans. The Alaska plan has just recently started.

Oregon already has 20,000 members signed on an individual basis and thus has accumulated some actuarial data on this type of membership. California has two counties in which individual membership is being tried out experimentally. The state is preparing to extend this service by midsummer.

Cutter Laboratories Plead Nolo Contendere in Hearing on Contamination of Flasks

SAN FRANCISCO.—Cutter Laboratories pleaded nolo contendere in San Francisco Federal Court here last month at a hearing on contamination found a year ago in flasks prepared and shipped by the laboratory. Officials of the company explained that it would serve no useful purpose to put the company and the government to the expense of a long, drawn out hearing to establish a legal opinion as to whether the contamination occurred before or after shipment. "The fact remains," laboratory officials stated, "that, to our deep regret, the contamination actually did occur, in spite of all precautions against just such a happening."

When the recall program got under way, the company not only cooperated with the Food and Drug Administration in recovering the flasks in question but went farther and voluntarily recalled from the market all solutions produced in the same department as a safeguard against even the remote possibility that other flasks might have been contaminated, it was recalled.

NEWS...

"Dollar Barrier" Endangers Nation's Health, F.S.A. Official Tells Students

NEW YORK CITY.—Speaking to fourth year medical students at the College of Physicians and Surgeons, Columbia University, J. Donald Kingsley, acting Federal Security Administrator, contended that the nation's health is being endangered by the dollar barrier between physician and patient.

"The cry of socialism directed against our proposal for a national health insurance program is in essence the very argument used a hundred years ago to try to defeat the idea of free public school education," Mr. Kingsley declared. "And during the last century the same tactics have been employed in trying to defeat every piece of sound social legislation that has been advanced. Such charges were poppycock in 1849, and they are still poppycock in 1949."

Mr. Kingsley told the students that a young doctor setting forth in the practice of his profession would be able to look forward to a constructive and useful career under national health insurance. He added that "there will be plenty of patients, and all bills will be met promptly."

Doctors Consider Plan for Care of Civilian Casualties in Event of Another War

CHICAGO.—More than 100 representatives of state medical associations, the Office of Defense, army, navy and air forces attended a conference at the headquarters of the American Medical Association here to consider a national program for the care of civilian casualties in the event of another war.

Dr. Norvin C. Kiefer, medical adviser on civil defense planning to the Secretary of Defense, said the nation faced a "colossal problem in the care and treatment of casualties without any parallel in peace time or war time" in the event of another war. He urged the establishment of civilian defense organizations at state and local levels; a survey of existing medical manpower, facilities and supplies; a study of possible emergency facilities; a training program to familiarize physicians with treatment of casualties from new methods of warfare, and training of the lay public in large scale rescue work.

Existing shortages in hospital beds and some supplies and equipment, as

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NEWS...

well as in manpower, require that there be efficient use of these facilities, Dr. Kiefer said.

Dr. James A. Crabtree, medical director of the National Security Resources Board, said the government is making a survey of the existing medical resources. These, Dr. Crabtree added, must be weighed against the needs of the nation in the event of a war and steps must be taken to make use of the resources to their utmost.

Dr. Richard L. Meiling, Columbus, Ohio, a member of the Armed Forces Medical Advisory Committee, Office of the Secretary of Defense, said his committee was studying a recommendation for the establishment of an independent medical department to serve all armed services. He pointed out that the army, navy and air force will require about 2200 doctors to take the place of physicians whose two-year service periods will expire this year. He urged that every effort be made to obtain this recruitment voluntarily before considering compulsive legislation. Dr. Meiling's proposal had the support of the medical profession.

Dr. Ernest B. Howard, Chicago, acting secretary of the Council on National Emergency Medical Service, detailed the program which has been undertaken by the American Medical Association to obtain doctors for the armed services. The campaign had been directed toward 8000 doctors and dentists who obtained their training at government expense and another 7000 who were deferred by the Selective Service in order to complete their own paid-for training.

The program of the armed services will not disturb the civilian supply of doctors, it was explained, because it does not call for additional physicians, merely replacements.

Clinic Patients Increase

MORRISTOWN, N. J.—Clinic visits at Morristown Memorial Hospital totaled 3223 during the first three months of this year, as compared with 1956 visits during the January-March period of 1948, the hospital reports. The increases show that more persons are finding it impossible to pay for medical care, as compared with a year ago, as a careful financial check is made of each person who applies for clinic care before he is accepted, hospital officials explained.

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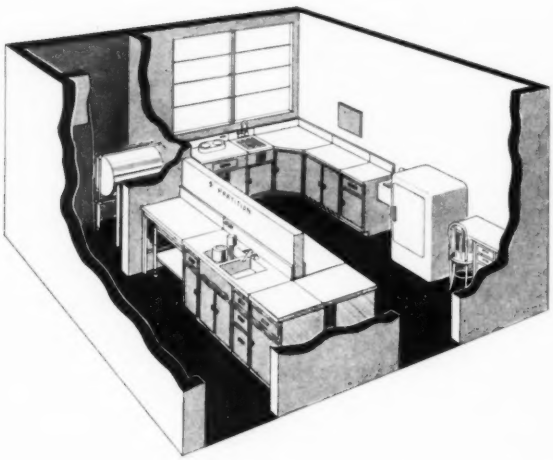

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1a. 85-L-24DSS—Drawer Cupboard Unit with Special-Depth Top
2. 85L-D3S—Table Top Units with 85X-27 Legs (3 Prs. Required)
3. 85L-72AS—Double Sink Unit
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9. 85L-24AS—Sink Unit with Stainless Steel Grill
10. 85L-39—Corner Unit
11. Bulletin Board
12. 85L-35—Cupboard Unit
13. 85L-24D—Drawer-Cupboard Unit
14. Lavatory
18. 85ES-2—Electrical Duplex Plug Strip

GROUP 2 (NOT FIXED)

4. Olson Bottle Washer
7. 85P6398AL—Waste Receptacle-Silver lustre Finish
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15. Refrigerator
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17. 85P6327AL—Chair—Silver lustre Finish
19. 85P6356—Milk Cart

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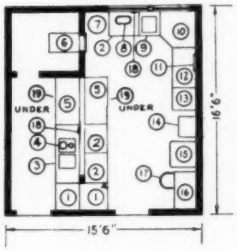

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ABOUT PEOPLE

(*Continued From Page* 78.)

spent four years at Johns Hopkins Hospital, Baltimore, where she held various executive positions in the nursing department. Before going to Johns Hopkins Miss Reich had been in charge of the Lutheran Hospital program in China for 16 years.

L. Louise Baker, former superintendent of nurses at Children's Hospital, Los Angeles, is now superintendent of nurses at Children's Hospital, Oakland, Calif. She succeeds **Mrs. Janet Korngold,** who is returning to Touro Infirmary, New Orleans, after an absence of many years.

Mary A. Jackson has been appointed director of nursing education at St. Luke's Hospital, Boise, Idaho, succeeding **Mrs. Esther DePartee.** Miss Jackson has been on the teaching staff at University of Oregon School of Nursing for the last year.

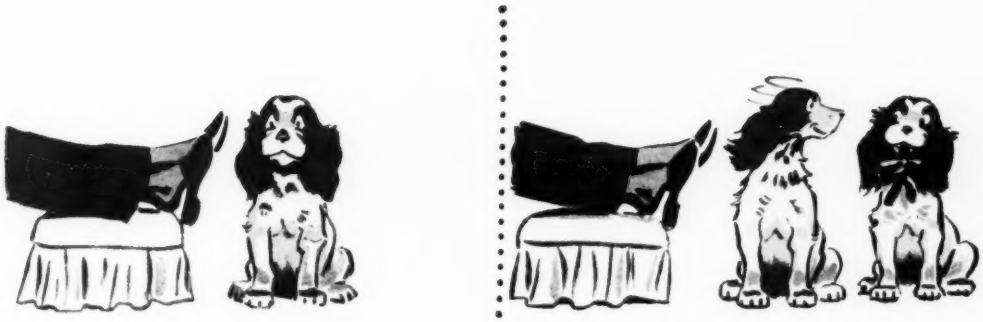
Harvey Schoenfeld, director of personnel, St. Vincent's Hospital, New York City, was reelected president of the Association of Hospital Personnel Executives at the last meeting of the association, held at the Associated Hospital Service Building, it was announced recently. **W. Terry Oliver,** personnel director, Roosevelt Hospital, New York City, was reelected vice president and treasurer and **Annette Auld,** personnel director, Brooklyn Hospital, Brooklyn, N.Y., recording secretary.

Named as members-at-large were **John G. Dale Jr.,** personnel director, New York Hospital, and **Mrs. Viola Herschman,** personnel director, Jewish Hospital of Brooklyn.

Miscellaneous

Dorothy E. Clark, formerly director of nursing at the New Jersey State Hospital, Greystone Park, has been appointed nursing consultant of the committee on psychiatric nursing of the American Psychiatric Association to succeed **Mrs. Lela S. Anderson.** Prior to going to Greystone Park, Miss Clark had experience as psychiatric supervisor at Michael Reese Hospital, Chicago, and at Milwaukee County Hospital, Wauwautosa, Wis.

Dr. Joseph F. VanAckeren, who has been in charge of Baltimore Marine Hospital since 1944, will transfer August 1



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to Seattle Marine Hospital as medical officer in charge. He was commissioned in the U.S. Public Health Service in 1927. In his new post he succeeds **Dr. Paul D. Mossman,** who will become medical officer in charge of Marine Hospital, Portland, Me., August 25.

Dr. James R. Shaw, medical officer in charge of U.S. Public Health Service Outpatient Clinic in Los Angeles, will transfer August 1 to Detroit Marine Hospital, where he will be medical officer in charge, succeeding **Dr. Donald W. Patrick,** who is leaving his post at Detroit Marine Hospital, where he has been in charge since 1947, to become medical officer in charge at Baltimore Marine Hospital August 1.

Dr. David J. Zaugg, who has been medical officer in charge at San Juan Marine Hospital, San Juan, P.R., since 1947, is leaving August 1 to attend the University of Chicago School of Hospital Administration for the coming year. Succeeding him at San Juan will be **Dr. William Y. Hollingsworth,** medical officer in charge at San Francisco Marine Hospital since 1944. Dr. Zaugg was commissioned in the Public Health Service in 1936 and Dr. Hollingsworth in 1920.

Dr. Charles R. Mallary has been assigned medical officer in charge at San Francisco Marine Hospital. For the last two years he has been the hospital's deputy medical officer in charge. Succeeding him in that position will be **Dr. Harold T. Castberg,** who has been with Public Health Service Outpatient Clinic in Washington since 1948.

Dr. Edward K. Reid, deputy medical officer in charge of Chicago Marine Hospital for the last year, has been named medical officer in charge at Ellis Island Marine Hospital. Dr. Reid succeeds **Dr. Lionel E. Hooper,** who has been transferred to the Public Health Service Quarantine Station and Outpatient Clinic at Miami as medical officer in charge.

Dr. Fletcher C. Stewart, medical officer in charge of the U.S. Public Health Service Outpatient Clinic, Hudson and Jay, New York City, is now medical officer in charge of the U.S. Public Health Service Outpatient Clinic at Los Angeles. **Dr. Samuel J. Hall** is the new medical officer in charge at the Hudson and Jay Outpatient Clinic. He went there from Seattle Marine Hospital, where he was deputy medical officer in charge for two years.

Dr. William W. Nesbit is now medical officer in charge at New Orleans Marine Hospital. He transferred to his new post from Galveston Marine Hospital, where he was in charge for the last three years. **Dr. Harold D. Lyman,** who succeeds him at Galveston, transferred there from Buffalo Marine Hospital, where he served as medical officer in charge since 1947.

Dr. William H. Gordon is the newly appointed medical officer in charge of the U.S. Public Health Service Outpatient Clinic, Houston, Tex. He was assigned to Houston from New London, Conn., where he was chief medical officer at the U.S. Coast Guard Academy for five years. Succeeding Dr. Gordon as chief medical officer at the academy is **Dr. Edwin H. Carnes,** medical officer in charge of New Orleans Marine Hospital since 1944.

Deaths

Dr. Alexander Goldman, founder and first president of the Bronx Hospital, New York City, died June 16 at the age of 77 years.

Dr. Ray Lyman Wilbur, chancellor of Leland Stanford University and former Secretary of the Interior in President

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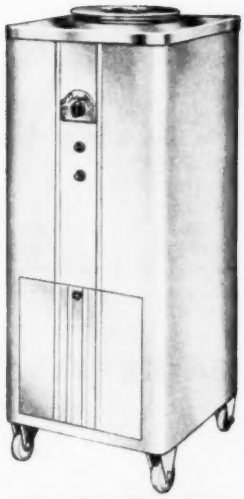

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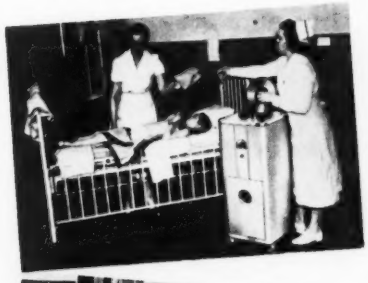

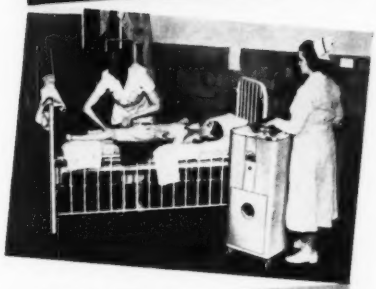

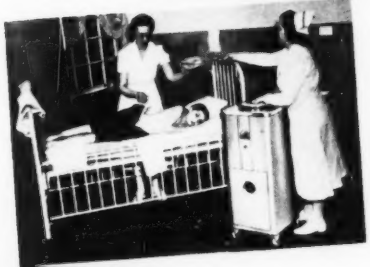

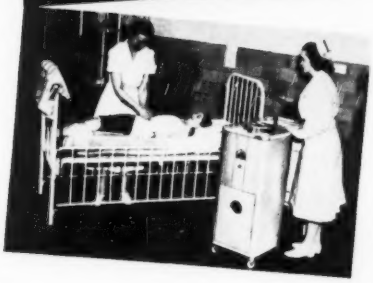

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Hoover's Cabinet, died June 26 in Palo Alto, Calif. He was 74 years old. Dr. Wilbur was president of the American Academy of Medicine in 1912-13 and of the American Medical Association in 1923-24.

Dr. Mayo H. Soley, 42, Dean of the State University of Iowa Medical College, committed suicide June 21. In addition to his duties at the medical college, Dr. Soley was director of medical services of the University Hospitals and research professor in the department of internal medicine.

THE BOOKSHELF

HOSPITALS, *The Journal of the American Hospital Association, Part II, Statistics and Directory Section. Chicago: June* 1949.

This annual listing of hospitals and presentation of statistical and financial facts on the hospitals of this country provides much information of value to hospital planners.

The section on the hospital plant summarizes in an interesting and readily usable form many facts on the size, type and control of hospitals. Total assets per bed as disclosed by questionnaires returned by more than 6100 hospitals show the striking differences between short-term, general acute hospitals and those used for long-term mental and tuberculosis cases. The figure of $7844 of assets per bed for the former and $1902 per bed for mental hospitals may well disclose a fundamental weakness in our mental hospitals. Many modern authorities feel that society has been penny-wise and pound-foolish in not providing for more scientific and suitable facilities for the care and prevention of mental illness.

Figures taken from state surveys and master hospital plans under Public Law 725 (Federal Hospital Survey and Construction Act) are impressive and indicate the tremendous hospital administration program to be carried out over the next 10 to 15 years.

The survey figures on various diagnostic facilities show that even small hospitals (under 50 beds) are steadily improving community health services.

The chapter on use of the plant offers a wealth of research material to guide hospital planners. Of particular interest are the figures on percentage occupancy and average length of stay given by regions.

The chapter on plant operation shows that the average cost per patient day in 1948 was $14.06 for nonprofit general short-term acute and allied hospitals. When this is compared with an average cost of about $6 per day before the war, it is easy to understand why most nonprofit hospitals are in financial difficulty. It is too bad that figures on the average percentage of federal, state, city, county and township indigent patients and the average payment per day for these patients were not made a part of the statistics. These figures would have vividly presented the chief financial headaches of a majority of our voluntary hospitals.

The sections devoted to hospital listings and data on allied organizations and the general information on the association are all well presented. The editors are to be congratulated on a difficult job well done.—E. W. JONES.

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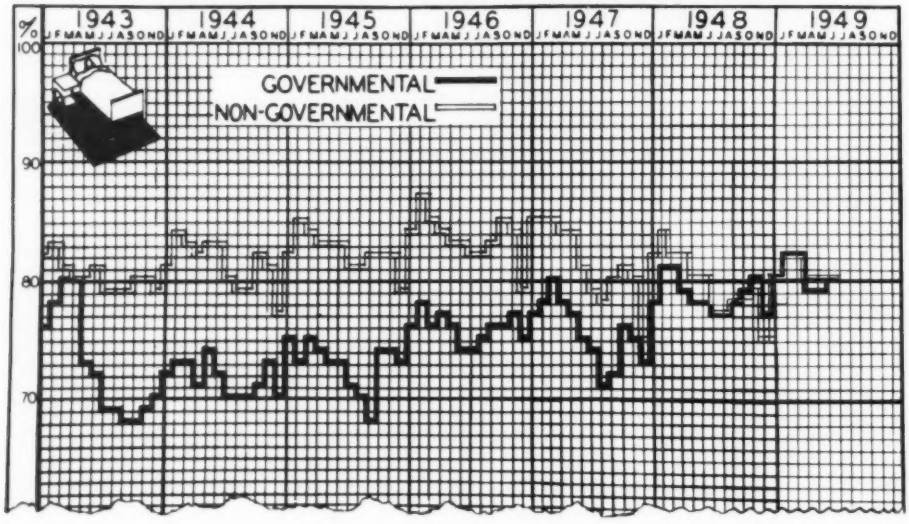
Occupancy Continues at Subdued Levels



Occupancy of nongovernmental hospitals continued at subdued levels compared to previous years, with 79.7 per cent of beds occupied in reporting hospitals during the month of June. Governmental hospitals reported 79.6 per cent occupancy for the same period—up a little over June a year ago.

New construction reported was somewhat less than the construction total for the same period last year—$18,795,000 compared to $23,203,000 in 1948. Total reported for the year to date was $294,521,000 as against $375,891,000 at this time last year. New hospitals reported last month averaged $2,300,000 each in estimated construction cost.

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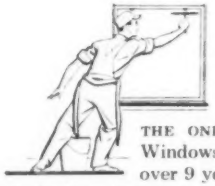

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have these "plus" features:

- **Minimum Air Infiltration**
- **Finger-tip Control**
- **No Warp, Rot, Rattle, Stick**
- **No Painting or Maintenance**
- **Ease of Installation**

THE Adams & Westlake COMPANY

Adlake TRADE MARK

Established 1857 • ELKHART, INDIANA • New York • Chicago

Patients Recover Faster

IN A CALM, QUIET HOSPITAL

Acousti-Celotex has made this 4-bed ward in the new Hartford Hospital, Hartford, Conn., a restful haven of sound conditioned quiet.

No matter how efficiently any hospital is planned, routine operation creates noise which *directly* affects the patients and nurses. How that noise is handled can make the difference between slow or rapid recovery of patients, between ease or strain on nurses.

Unchecked noises echo and re-echo down hallways, into wards and around the rooms. Little by little, they pile up into one constant din that irritates everyone in the building.

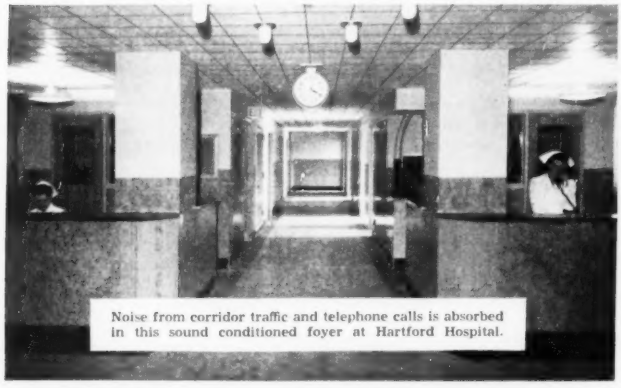
Modern Sound Conditioning absorbs unwanted hospital noise from ringing bells, clattering dishes and distracting conversation. Immediately, voices are muted, doors shut quietly and calm, relaxing quiet replaces disturbing noise.

For many years, now, Acousti-Celotex has been bringing beneficial quiet into hospitals from coast to coast.

Your noise problem, too, can be solved quickly with this modern acoustical ceiling tile that *can be painted and washed repeatedly* without diminishing its high sound-absorbent efficiency.

Contact your nearest Acousti-Celotex distributor (United States or Canada) for a complete, free analysis of the noise problem in your hospital. Or write directly to The Celotex Corporation, 120 South La Salle Street, Chicago 3, Illinois.

ACOUSTI-CELOTEX
Sound Conditioning
PRODUCTS FOR EVERY SOUND CONDITIONING PROBLEM



Noise from corridor traffic and telephone calls is absorbed in this sound conditioned foyer at Hartford Hospital.

Hartford Hospital's diet kitchen is sound conditioned with Acousti-Celotex to quiet the clamor of preparing patients' meals.

FOR

ECONOMICAL-

CONTROL OF FORCED HOT WATER HEATING SYSTEMS

USE-

Mastrol

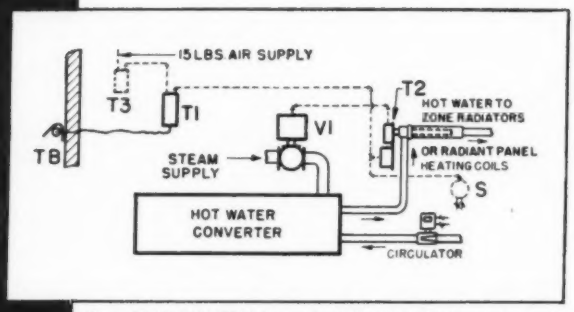
DEPENDABLE, LOW MAINTENANCE COST SYSTEM of Pneumatic Temperature Control FOR SCHOOLS • HOSPITALS • COMMERCIAL, INDUSTRIAL AND APARTMENT BUILDINGS

WITH a Powers MASTROL System of control, comfortable indoor temperatures can be obtained at a low initial cost. Fuel savings alone resulting from elimination of OVER-heating pay back a large return on a relatively small investment.

HOW IT WORKS—The Powers MASTROL system consists of two controllers. The outdoor instrument is the Master control and the indoor hot water controller is the Sub-Master regulator. The master control, conveniently located inside the building, has a thermal system consisting of armored flexible tubing and a sensitive bulb placed on an outside wall. The master control quickly responds to changes in outdoor temperature and pneumatically resets the control point of the sub-master regulator which varies the hot water temperature in direct relation to the outdoor temperature.

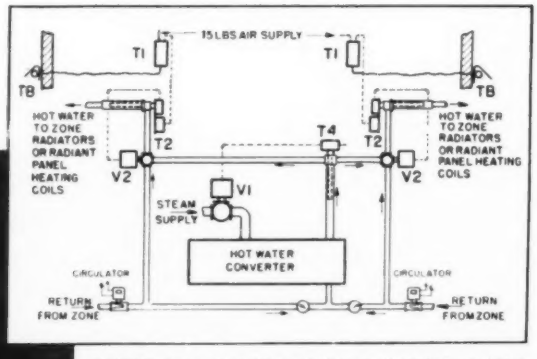
Users report "Very Low Maintenance Cost and Dependable Operation". When you want these advantages in a control system for forced hot water heating contact our nearest office or write 2720 Greenview Ave., Chicago 14, Ill.

MA



Above, POWERS MASTROL System Controlling Hot Water Supply for Single Zone with Pilot Room Thermostat. T8-Outdoor thermal bulb and shield. T1-Master control, T2-Sub-master regulator. T3-Pilot thermostat 68°F. for quick warm up (optional). V1-Diaphragm control valve for steam. S-Switch to automatically stop circulator when outdoor temperature is above 60°F., (optional).

Powers MASTROL Control System—One of several combinations of Powers Master-Sub-Master controls for Forced Hot Water Heating Systems.



MASTROL System Controlling Hot Water for Multiple Zones Using 3-Way Water Mixing Valves—T8-Outdoor thermal bulb and shield. T1-Master control. T2-Submaster regulator. T4-Regulator for Maximum hot water control. V1-Diaphragm Control Valve for steam. V2-Three-way water mixing valve.

THE

POWERS

REGULATOR COMPANY

OVER 55 YEARS OF TEMPERATURE CONTROL

Offices in 50 Cities • See Your Phone Book

for

"Environmental Therapy"

...start with a

TILE-TEX FLOOR

This *quality* Asphalt Tile gives you a wide range of colors and sizes to help you design floors that do important Decorative and Functional work.

Everyone recognizes the importance of bright, cheerful surroundings during convalescence. And the best beginning in that direction is a properly designed floor of smooth-surfaced Tile-Tex* Asphalt Tile.

The tile-at-a-time method of installation gives this colorful flooring material versatility that lets you have your own way with pattern design. Stripes, squares, checkerboard, basket-weave . . . with Tile-Tex, it's virtually a matter of "name it, and you can have it." You can even design special inserts for decorative or functional purposes.

But just because Tile-Tex has versatility and beauty, don't think of it as a fragile material. It's *exceptionally durable*. Some Tile-Tex floors have been in constant service for more than 20 years, without visible signs of wear.

Comfort is another Tile-Tex advantage, too. The resilient tiles provide a pleasant surface to walk and work on . . . for patients and staff alike.

To all these advantages, add low material cost, fast and economical installation, rock-bottom maintenance . . . and the result is the floor you want: *Tile-Tex Asphalt Tile!*

Get complete information on this modern flooring material, and how it can help you add "environmental therapy" to every patient's program. For descriptive literature, and the name of your nearest Tile-Tex Contractor, write: THE TILE-TEX DIVISION, The Flintkote Company, Chicago Heights, Illinois. Sales offices: Chicago, New York, Los Angeles, New Orleans, Toronto and Montreal.

Asphalt TILE-TEX Tile

TILE-TEX...The *Quality* Asphalt Tile

GENERAL ELECTRIC

Germicidal Tubes...

HELP MAKE BREATHING SAFER!

● If everyone stayed out of doors in fresh air, breathing would always be safe. But the indoor air of occupied nurseries and wards may be carrying germs that menace patients health!

You can reduce this risk by disinfecting the air with the ultraviolet energy of General Electric Germicidal Tubes.

These amazing tubes quickly kill 95% or more of the germs in air exposed to their energy. They help make breathing safer.

FACTS YOU SHOULD KNOW

- General Electric Germicidal Tubes produce ultraviolet energy.
- G-E Germicidal Tubes kill 95% or more of the germs in the air through which the energy passes.
- G-E Germicidal Tubes must be used in properly designed and correctly installed fixtures to prevent irritation of human eyes and skin. Usually the tubes are placed to disinfect the area in a room above eye level.
- The number of germs in air is reduced as disinfected air from upper areas circulates down to breathing areas. However, ultraviolet energy cannot prevent respiratory infections being spread by close contact.
- The Council on Physical Medicine of the American Medical Association has accepted G-E Germicidal Tubes for air disinfection in hospital wards, nurseries and operating rooms.

GENERAL ELECTRIC

Write for free booklet "Air Sanitation" and a folder on hospital use of G-E Germicidal Tubes. Address General Electric, Dept. 166-MH8, Nela Park, Cleveland 12, O.

The casement type window illustrated closes and locks tightly, yet can be opened instantly to supply any amount of ventilation required without moving or opening insect screen. Lupton windows are also available in projected types.

COME into the laboratory . . . See what a difference Lupton Metal Windows make in this important hospital department. Clear, effortless vision is provided for every corner of the room. Narrow metal frames increase glass area, make rooms brighter, more cheerful. Ventilators close tightly, preventing excessive air infiltration, yet they can be opened instantly when outside air is required. Close fitting, all-metal insect screens are available for all openings.

Where rooms are completely air conditioned, fixed metal frames can be supplied for glazing with single or double glass.

Lupton Metal Windows are made for lifetime service. Sturdy steel frames cannot warp, swell, shrink or rattle. All windows are Bonderized to increase the effective life of finish paint, and are available with hot-dip galvanized finish for locations subject to acid fumes and extreme moisture. The Lupton Representative will gladly give you full details — or write for our General Catalog.

MICHAEL FLYNN MANUFACTURING CO.
700 East Godfrey Avenue, Philadelphia 24, Penna.
Member of the Metal Window Institute

LUPTON METAL WINDOWS

another big Duraclay installation!

JOHNSON COUNTY MEMORIAL HOSPITAL
FRANKLIN, INDIANA

Yes, it's Duraclay again . . . here in Johnson County Memorial Hospital as in so many leading institutions all over the country.

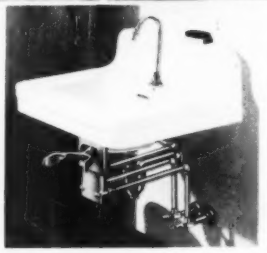
And for so many good reasons! Among them: Duraclay cleans with the swish of a damp cloth. It is completely immune to thermal shock—won't crack or craze despite extreme changes in water temperature. Strong acids? No, they won't harm Duraclay, either. But, most important, neither will *time*—Duraclay retains its bright, clean sparkle through years of constant usage.

You'll want Crane Duraclay in every department where long, hard service is required of plumbing fixtures. And you can *have* Duraclay, too—it comes in a complete line of hospital sinks and baths.

Make your selections through your nearby Crane Branch, Crane Wholesaler, or your local plumbing contractor. And be sure to write for your Crane Hospital Catalog.

At right, diet kitchen sinks of Crane Duraclay; below, Duraclay scrub-up sinks, all on duty in the Johnson County Memorial Hospital.

Left and below: Besides the full line of Duraclay items, Crane supplies such hospital necessities as the drinking fountain, lavatory, and medicine sink pictured here. In fact every last requirement in hospital plumbing—however specialized—is part of the broad Crane line.



Duraclay exceeds the rigid tests imposed on earthenware (vitreous glazed) by Simplified Practice Recommendation R-106-41 of The National Bureau of Standards.

CRANE

CRANE CO., GENERAL OFFICES:
836 S. MICHIGAN AVE., CHICAGO 5, ILLINOIS
PLUMBING AND HEATING • VALVES • FITTINGS • PIPE

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

ARM CHAIR NO. 225

SIDE CHAIR NO. 220

new Life-Long chairs created especially for hospital service

Patients and visitors relax in these posture comfort chairs, cushioned with Dunlop Pillo-Foam, or deep inner spring cushions. Fresh modern lines add new attractiveness to hospital room groupings.

Heavy tubular construction guarantees strength and durability. Rear legs project to prevent chair backs from marring and scratching wall. Upholstered with washable Duran Plastic Fabric, Life-Long chairs are easy to keep clean and sanitary.

Write for complete specifications.

HARD MANUFACTURING CO.

BUFFALO 7, NEW YORK

Sold only through recognized hospital and surgical supply dealers

EASY CHAIR NO. 230

OTTOMAN NO. 235

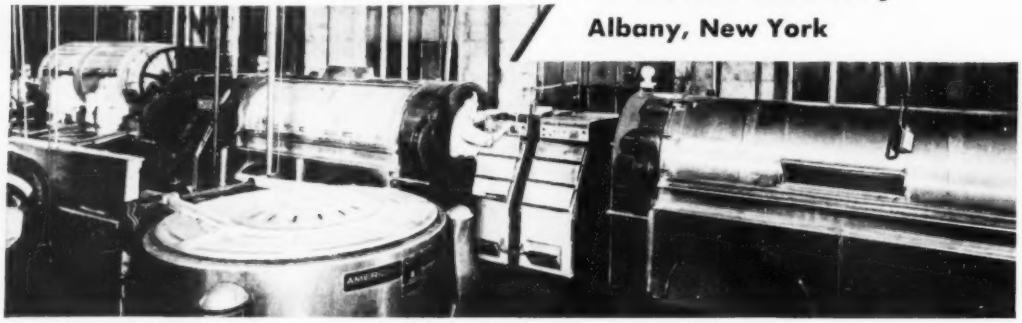
NO TIP FOOT STOOL 104

Mechanizing with MONEL...

Increases Washroom Output 40%

at DuRite Laundry

Albany, New York



Three men run this modern, automatic washroom. *It used to take six.*

And four American machines of Monel* now turn out 40% more work than the nine old-fashioned machines they replaced!

Yet these are not the only advantages that DuRite Laundry gets from mechanizing with Monel.

Savings All Around

DuRite today is using 30% less supplies, 20% less steam and 20% less power. They are saving $1,000 a year on water. And their three new 42" x 96" *Cascade* automatic unloading washers with "Companion Controls," plus their single new 54" Notrux extractor (that saves as much as 21 man-minutes each load) take only half as much floor space as their old equipment.

Mechanize for Mass Production

You, too, can turn out more work — more rapidly and more economically — by changing over to push-button washroom operation. For here's how it helps you . . .

First, by unloading automatically in less than a minute, a Cascade Automatic Unloading Washer actually saves about 9 minutes' time and labor each load.

Next, Cascade washing control eliminates up to 59 costly, time-wasting manual operations on *every* load. Only three simple jobs are left for your washmen to handle; automatic controls take care of everything else.

Your entire washing cycle is mechanically controlled. You save supplies. You have shorter runs. You get uniform quality washing — *every time.*

Monel Means Protection

With Monel, you never worry about rust stains or corrosion. A solid Nickel Alloy, Monel can't rust. It resists corrosion by soaps and built detergents, stands up against alkalis and starches, dilute bleaches and fluoride sours. Your washer cylinders and extractor baskets stay smooth, always free of pits and rough spots.

Stronger and tougher than structural steel, Monel equipment is not only long-lasting but economical to operate. It keeps turning out work year after year, seldom needs more than routine inspection and maintenance.

To the proved advantages of Monel, add the *extra* benefits of a fully mechanized washroom — *and you have a doubly efficient combination.*

*Reg. U. S. Pat. Off.

EMBLEM OF SERVICE
INCO
TRADE MARK

THE INTERNATIONAL NICKEL COMPANY, INC.

67 Wall Street, New York 5, N. Y.

From PARK AVENUE

TISHMAN REALTY & CONSTRUCTION CO. BLDG., New York.
Architect: Kahn and Jacobs; Consulting Engineer: Jaros, Baum and Bolles;
Heating Contractor: Peter Sinnott Heating Co. Inc.

To MAIN STREET

LUTHERAN MUTUAL INSURANCE CO., Waverly, Iowa.
Architect: Mortimer B. Cleveland;
Heating Contractor: Rynearson & Koch, Inc.

DUNHAM DIFFERENTIAL HEATING

cuts fuel costs up to 40%

Provides unsurpassed comfort year 'round . . . in any climate

For a multi-story skyscraper . . . as for a single-story structure . . . Dunham Vari-Vac* Heating permits you to slash fuel costs as much as 40%.

Possible? Not only possible, but already proved so conclusively in installations all over the country that Dunham has guaranteed, in writing, a fuel reduction of 25% for many buildings. Such savings are possible because Vari-Vac automatically provides the precise amount of heat you require by utilizing a *continuous* flow of steam at *temperatures that vary with the weather.*

Job-scaled to Your Size

Dunham engineers recently perfected methods of job-scaling this variable vacuum system to fit any size or type of building . . . regardless of climatic conditions. Seven different systems . . . from a Basic to a Supreme installation . . . are available to you. A Dunham engineer can quickly tell you which size you need.

For increased comfort every hour of every day . . . for a heating system that stays on the job year after year . . . and for that *all-important reduction in your operating costs* . . . investigate Dunham Vari-Vac today.

Variable Vacuum

FREE BOOKLET TELLS ALL

Bulletin 509 gives you complete information for "Job-scaled" Vari-Vac Heating; tells you what it is, how it operates, how it may be fitted exactly to your needs. For your copy, write

C. A. Dunham Co., 400 W. Madison Street, Chicago 6, Ill.
In Canada: C. A. Dunham Co. Ltd., Toronto.
In England: C. A. Dunham Co. Ltd., London.

CONVECTOR RADIATION
TRAPS

DUNHAM

BASEBOARD RADIATION, UNIT HEATERS,
VALVES, PUMPS

HEATING MEANS BETTER HEATING

IT CAN BE DONE
...but don't try it!

Sometimes it's possible to break all the rules—and get away with it.

The famous Tower of Pisa, for instance, has successfully defied both sound engineering practice and the law of gravity for over 800 years.

But for most of us, most of the time, the rules hold.

That is particularly true when it comes to saving money.

The first rule of successful saving is *regularity* . . . salting away part of every pay check, month after month.

Once in a blue moon, of course, you'll come across someone who can break that rule and get away with it. But the fact is that most of us *cannot*.

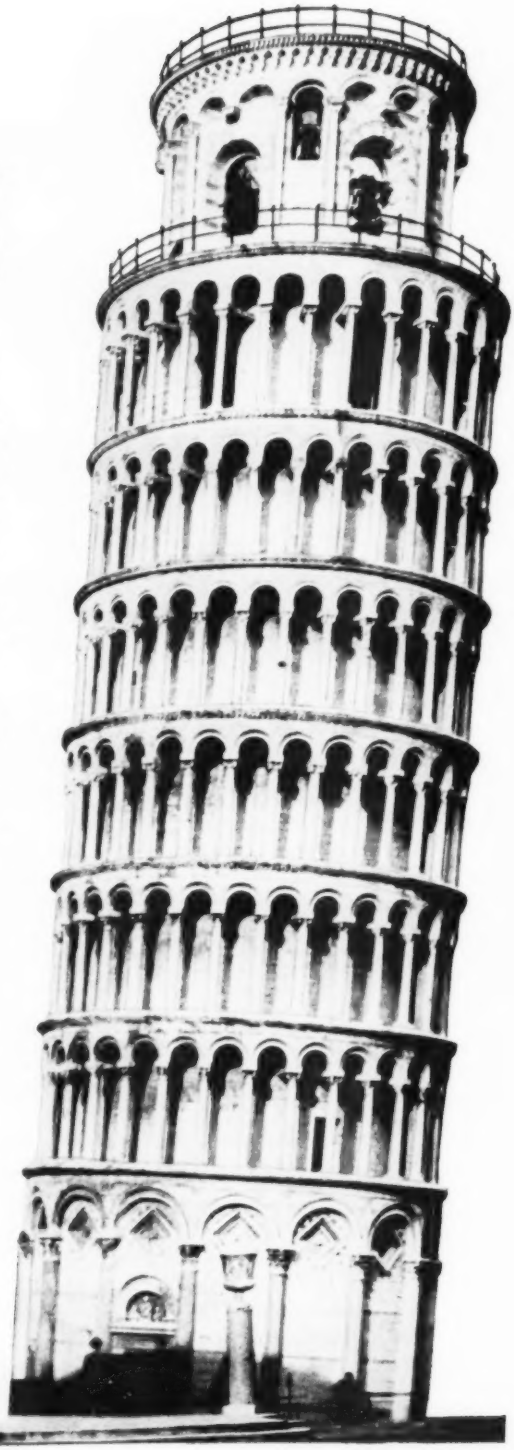
For most of us, the one and only way to accumulate a decent-size nest egg for the future and for emergencies is through regular, automatic saving.

In all history there's never been an easier, surer, more profitable way to save regularly than the U. S. Savings Bond way.

Those of us on a payroll are eligible to use the wonderful Payroll Savings Plan. The rest of us can use the equally wonderful Bond-A-Month Plan through our local bank.

Use whichever is best for you. But—*use one of them!*

AUTOMATIC SAVING
IS SURE SAVING—
U. S. SAVINGS BONDS



Contributed by this magazine in co-operation with the Magazine Publishers of America as a public service.

"We take rush hour meals in stride now that we've installed a McCray Koldflo in our kitchen!" says *Mr. Earl W. Davis, Toledo, Ohio*

New McCray Koldflo 60 cu. ft. Reach-In

"Feeding a lot of hungry people in a hurry is a big job. That is, it *was* a big job before we got a new McCray Koldflo.

"Previously meal time meant bending every effort to prepare enough dishes to meet the demand. Now we prepare many dishes—such as salads and desserts—hours before they're needed. We never worry about spoilage because this McCray Koldflo keeps all foods at the *right* temperature.

"Also, we can keep far *more* food completely refrigerated in the big storage compartments of a McCray Koldflo without danger of waste.

"F. I. Davison, McCray distributor here in Toledo, sure called it when he said we'd be money ahead with a McCray Koldflo. In all of my experience with refrigerators in commercial kitchens, this one takes top honors for efficient, dependable service."

For smaller installations, this McCray Koldflo 30 cu. ft. Reach-In contains all of the desirable features of the larger model above—including famous McCray Koldflo "Up-from-under" controlled refrigeration for proper balance of humidity, temperature and circulation. Also available in 20 and 40 cu. ft. sizes.

Earl W. Davis

Operator and Chef, Hickory House Cafeteria, Toledo Scale Company, Toledo, Ohio

McCray
KOLDFLO

THE BEST IN LOW-COST REFRIGERATION

WRITE 966 McCRAY COURT, KENDALLVILLE, IND. DISTRIBUTORS IN PRINCIPAL CITIES—SEE TELEPHONE DIRECTORY

Canned Foods as a Source of Thiamine (Vitamin B_1)

NO. 3 in a series which summarize the conclusions about canned foods reached by authorities in nutrition research.

Thiamine, the anti-neuritic vitamin, is perhaps the best known member of the B complex. It promotes growth, is essential in carbohydrate utilization, and helps maintain normal appetite and proper intestinal function. (1)

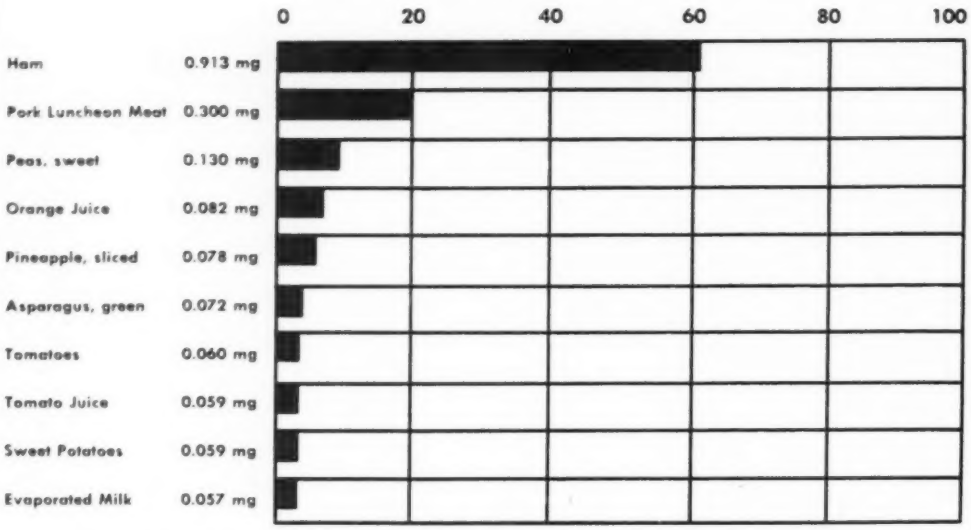
Only a few foods can be classified as rich sources of thiamine; they include peas, beans, oatmeal, whole wheat, lean pork, and peanuts. Fruits, vegetables, and milk, however, must not be overlooked since they may contribute appreciable amounts of thiamine, although the amount per unit of weight is relatively low. (2)

Since thiamine is derived from a number of foods, each of which contribute a small amount of this essential nutrient, the wide variety of foods made available throughout the year by commercial canning will assist in the acquisition of an adequate supply of Vitamin B_1.

Canned foods which contribute 5% or more of the Recommended Daily Allowance include pork luncheon meat, peas, orange juice, sliced pineapple, and green asparagus. (3)

Percentage of Recommended Daily Allowance* in 4-oz. (113 grams) Serving (3)

(Based on analysis of the entire can contents)



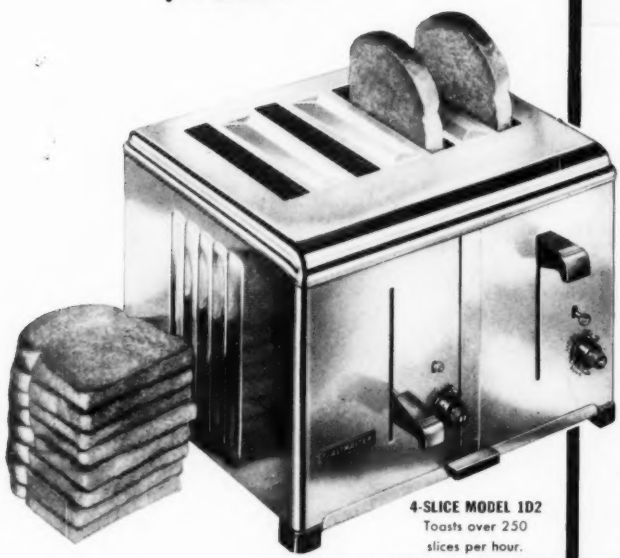
*Percentage based on Recommended Daily Allowance—1.5 mg. for moderately active male—National Research Council.

(1) 1943. Chemistry of Food and Nutrition. H. C. Sherman. Page 355. MacMillan, New York.

(2) 1943. Handbook of Nutrition, A. M. A. Council on Foods and Nutrition. Page 215. American Medical Association, Chicago.

(3) 1947. The Canned Food Reference Manual. American Can Company. Pages 247-48. Rogers-Kellogg-Stillson, New York.

There's a TOASTMASTER TOASTER *to fit every Hospital Need!*



4-SLICE MODEL 1D2
Toasts over 250 slices per hour.
$99.50, Fair Trade Price.
(Fed. Excise Tax Incl.)

WHETHER YOUR HOSPITAL is large or small, you'll find "Toastmaster" Toasters are best suited to fit *all* of your toasting needs.

YOU'LL SAVE TIME with the "Toastmaster" Toaster. It's completely automatic to free your staff for other duties. Just put in the bread, push down the lever, and forget it.

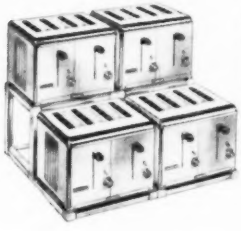
YOU'LL CUT COSTS because there's no scraping, no retoasting . . . every slice is perfect. Saves electricity, too . . . only the slots actually toasting use current. Ruggedly constructed, the "Toastmaster" Toaster is built to give you many years of service.

YOU'LL SAVE STEPS and valuable time for your personnel with a "Toastmaster"* Toaster in your diet kitchens. Many hospitals are using this idea now in addition to the larger-sized toasters in their main kitchens. The result is greater efficiency—more time for other tasks.

TOASTMASTER AUTOMATIC POP-UP TOASTERS

*"TOASTMASTER" is a registered trademark of McGraw Electric Company. Copr. 1949, TOASTMASTER PRODUCTS DIVISION, McGraw Electric Company, Elgin, Illinois.

Real Flexibility . . . 2 to 16 Slices Per Minute



FOR THE MAIN KITCHEN
The 16-slice, Model 4-1D2-D (left), is ideal for main hospital kitchens. That's because it has plenty of toasting capacity—pops up over 1000 slices per hour!
$410.00, Fair Trade Price.
(Fed. Excise Tax Incl.)

FOR THE DIET KITCHENS
The 2-slice, Model 1BB4 (right), is perfect for diet kitchens. It pops up over 125 slices of toast per hour. Equipped with cord to plug into any wall outlet.
$52.00, Fair Trade Price.
(Fed. Excise Tax Incl.)

Dept. G-89
TOASTMASTER PRODUCTS DIVISION
McGraw Electric Company, Elgin, Ill.

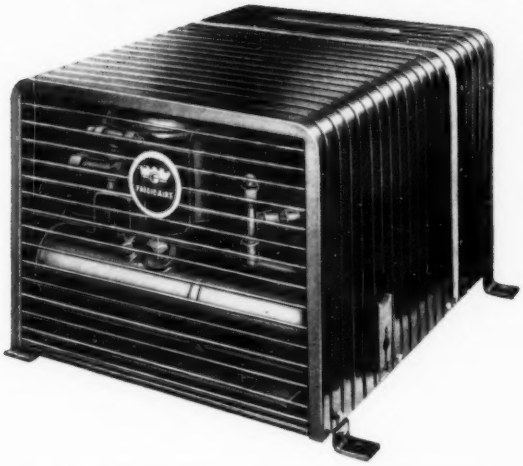
- ☐ Send me complete information on "Toastmaster" Toasters.
- ☐ Send me complete information on "Toastmaster" Roll and Food Warmers.

Name.....
Institution.....
Address.....
City.....*Zone*.....*State*.....
My Dealer's Name.....

Now—for commercial and industrial installations

A Brand-New Frigidaire Meter-Miser

at a wonderful new low price!



Here's a great new Meter-Miser Compressor, specially designed for self-contained or remote installation—ideal for use with virtually any type of refrigerating fixture. It's smaller, more compact—yet has all of the advantages that have made the Frigidaire Meter-Miser famous. And, best of all, it's yours at a wonderful new low price!

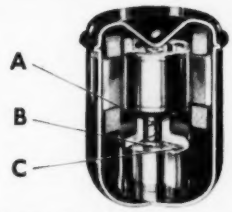
But it's not only the price that makes these superb new units your best buy. You save money every day with a Meter-Miser, for it's actually the simplest refrigerating unit ever built—trouble-free and amazingly thrifty. The Meter-Miser has been tested and proved in millions of Frigidaire products—carries its own special 5-Year Warranty.

The new Meter-Miser is available in ¼, ⅓ and ½ HP sizes. See it at your dependable Frigidaire Dealer's now. Find his name in the Classified Phone Book, under "Refrigeration Equipment." Or write Frigidaire Division of General Motors, Dayton 1, O. (In Canada, Leaside 12, Ont.)

New low prices on Meter-Misers for remote installations

The famous circular-type Meter-Misers are now also available at new low prices. Ideal for remote installation, they offer every operating advantage of the newer design.

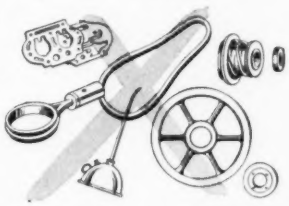
HERE'S PROOF— Meter-Miser means the best in commercial refrigeration!



A Direct Shaft from motor to compressor mechanism has microfinished bearing surfaces that are always automatically lubricated . . . oiled for life. It's easy to see why the Meter-Miser is so whisper-quiet!

B Impeller that compresses Freon refrigerant in the cylinder is so perfectly round and smooth that it rotates virtually without friction. No wonder the Meter-Miser is famous for long, trouble-free operation!

C Divider Block that works with the impeller to compress Freon refrigerant is made from special, extra-tough steel. Its accuracy is checked on sensitive electro-limit gauges capable of measuring millionths of an inch!



The Meter-Miser has no belts to break—no pistons and connecting rods to wear—no flywheels or pulleys to keep in line—no gaskets to leak. When parts aren't there, they can't cause trouble—can't waste current!

FRIGIDAIRE Meter-Misers

Short Cuts

TO BETTER FOOD SERVICE

Busy hospital dieticians appreciate the time-saving benefits of Dixie Cups and Containers when used regularly for food and drink service. Ideal for serving both hot and cold foods and drinks, Dixie Cups and Containers help speed portioning and distribution from kitchen to bedside. Paper keeps cold drinks *cold*, hot drinks *hot* — longer, and tight-fitting Dixie lids protect and hold foods at the peak of flavor and freshness until served.

DIXIE CUP SERVICE IS BETTER SERVICE BECAUSE IT'S...

SMOOTHER—Fewer delays in kitchen resulting from clutter of unwashed dishes or help absences. Fewer complaints resulting from beverages and foods reaching patients at distasteful temperatures.

QUICKER—Speeds distribution of bed-side meals and between-meal feedings — Dixies are always ready for instant use. Trays are lighter — less fretful waiting to be served.

QUIETER—No disturbing clatter of dishes by help or patients.

CLEANER—Used only once. Always fresh and appealing to eye and appetite.

SAFER—Constant protection of both patients and employees from mouth-borne infections.

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COLD DRINK CUPS for fruit juice, tomato juice, etc.

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As you know, CURITY Adhesive Tape has long been known for its "stick-to-it-iveness" and lack of skin irritation. But equally important, CURITY adhesive is made with a special cloth backing which makes it easier—far easier—to handle.

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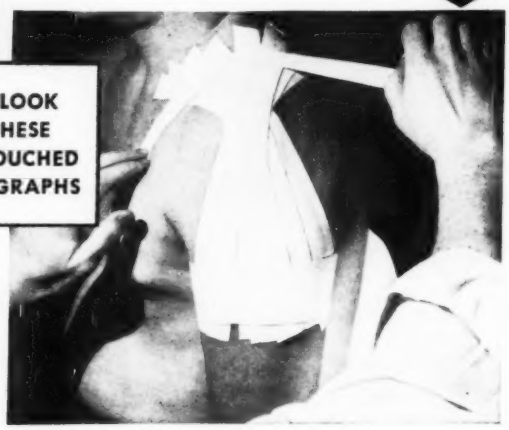

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More comfort for patients . . . less work for the staff . . . savings for your budget, too! You get all these features in Du Pont's "Fabrilite"* hospital sheeting, Quality 3510-U.

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This outstanding Du Pont hospital sheeting is kin to the "Fabrilite" that so beautifully upholsters hospital lounges and restaurants, reception-room walls and doctors' offices. "Fabrilite" upholstery and "Fabrilite" sheeting are made to stand abuse . . . made to *last* . . . for overall savings in the budget.

Next time you buy hospital sheeting, ask your supplier to show you Du Pont "Fabrilite" Quality 3510-U. Comes in standard-size rolls of 50 yards, or half-size rolls of 25 yards, 36" width. Remember—for hospital sheeting with *more good features*—always look to Du Pont! E. I. du Pont de Nemours & Co. (Inc.), Fabrics Division, Fairfield, Connecticut.

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WANT ADVERTISEMENTS

POSITIONS WANTED

ADMINISTRATOR—Male; age 37; desires appointment fifty to one hundred bed hospital; formal training and experienced in all phases of hospital administration; well recommended; available within sixty days; prefer middle west. MW 61, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Available; fifteen years' experience, planning and supervising new construction, reorganizing hospitals; successful operator, able to meet the public; age 38, married and will consider hospitals of 200 beds or larger; available immediately. MW 62, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—Medical; former assistant medical director of the Johns Hopkins hospital; also administrator, eight years, two large New York City teaching hospitals; immediately available. MW 63, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—General hospital; graduate staff; four years assistant, five years director nurses; prefer New York city or vicinity. MW 48, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PURCHASING AGENT—Or Assistant in large hospital; 23 years old; 3 years' experience; 3 years college, business administration; good references; west preferred. MW 57, The Modern Hospital, 919 N. Michigan Avenue, Chicago, Ill.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

DIRECTRESS—Nursing service, or school of nursing; B.S. Degree, Western Reserve University; registered, Ohio, New York; 2 years experience; organized school for PN.

ASSISTANT ADMINISTRATOR—Nominee, A.C.H.A.; Master's Degree, Hospital Administration, University of Chicago; 2 years executive officer, 400-bed Army hospital; 2 years assistant, 300-bed hospital, New York.

ADMINISTRATOR—Age 35; graduate, business administration; courses in hospital administration; 6 years assistant director accountant, large hospital, West Virginia.

ADMINISTRATOR—Age 45; MAHA Degree, Northwestern University; 5 years manager, 50-bed California hospital; 2 years administrative assistant, 300-bed hospital; past year organized new 100-bed hospital.

HOUSEKEEPER—Course, institutional management, Boston University; 7 years' experience.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATOR—Assistantship, large hospital, or directorship, small hospital preferred; M.S., Hospital Administration; accounting background CPA; year's administrative residency; available now.

ADMINISTRATOR—Graduate university school of nursing; M.A. eastern university; twelve years' experience, hospital administration; FACHA.

ADMINISTRATOR—Lay; B.A. degree, six years, assistant administrator, university group of hospitals, eight years, administrator, 300-bed hospital; FACHA.

ADMINISTRATOR—M.B.A. Hospital Administration; past several years, administrator, small hospital; prefers larger institution.

ADMINISTRATOR—Medical; five years' teaching; several years' successful general practice before specializing in hospital administration; since 1942, administrator, teaching hospital and on faculty, university school of public health and hospital administration.

ANESTHESIOLOGIST—Diplomate; university hospital training; past two years, full-time teaching anesthesiology university medical school.

DIRECTOR OF NURSES—Ph.D.; experience includes deanship, university school; teaching hospital preferred.

PUBLIC RELATIONS DIRECTOR—A.B., eastern university, several years, editorial staff, medical publishing company; eight years, director of public relations, medical foundation.

PHYSIATRIST—Several years' teaching experience; now completing three-year fellowship in physical medicine, university medical center.

RADIOLOGIST—Diplomate; three years' training, radiology, teaching center; two years, assistant radiologist, teaching hospital.

PATHOLOGIST—Diplomate; pathologic anatomy, clinical pathology; five years, director, laboratories, 400-bed hospital; eight years, professor clinical pathology, pathologist teaching hospital; considered one of leaders in pathology.

WOODWARD MEDICAL PERSONNEL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ASSISTANT ADMINISTRATOR—25; Dutch; Masters in Public Health; finishing comprehensive administration residency under recognized preceptor; immediately available.

Continued on page 200

WOODWARD—*Continued*

RADIOLOGIST—32; Board eligible; diagnostic, therapeutic; German-Scotch; training includes excellent residencies, fellowship, and several years' general private practice; willing teach part time; immediately available.

PATHOLOGIST—34; English; eligible, both Boards; graduate Harvard medical; experience includes several years, staff important large teaching hospital; presently assistant professor, pathology, western university; speaks Chinese, mandarian dialect; consider all localities, including foreign; immediately available.

POSITIONS OPEN

ADMINISTRATOR—Or Superintendent; for a 225-bed hospital; please state experience, references, and salary desired. MO 57, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Graduate nurse, in modern, well-equipped 200-bed Michigan hospital, located in lake area in close proximity to metropolitan Detroit; five anesthetists on staff; $285 base pay with $10 step increases at 6, 12, 24, 36 and 48 months; excellent cafeteria meals; uniforms laundered. Write Director, Pontiac General Hospital, Pontiac, Michigan.

ANESTHETIST—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

ANESTHETIST—Nurse anesthetist; wanted for 75-bed general hospital; congenial working conditions; ideal for individual wishing to become established in small city. Write full particulars to MO 47, The Modern Hospital, 919 N. Michigan Ave., Chicago 11.

ANESTHETIST—Nurse; must be member of A.A.N.A.; 250-bed modern hospital; maintenance available; service employing four anesthetists. Apply Administrator, Evangelical Deaconess Hospital, St. Louis 10, Missouri.

ANESTHETIST—400-bed general hospital; very pleasant working conditions; salary open depending on experience and ability. St. Joseph's Mercy Hospital, Ann Arbor, Michigan.

ANESTHETIST—Nurse; for 250-bed hospital; staff of three anesthetists; all agents and techniques used; no obstetrical night calls. Apply Director of Nurses, Columbus Hospital, Great Falls, Montana.

ANESTHETISTS—Nurse; for large general hospital; salary $3720.20 per annum; yearly salary increase; 40 hour 5-day work-week; overtime, when required, at time and one-half; annual accumulative leave for vacations and sickness; maintenance furnished, if desired, at $300 per annum; retirement benefits. Apply, Superintendent, Gallinger Municipal Hospital, Washington 3, District of Columbia.

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WANT ADVERTISEMENTS

POSITIONS OPEN

ANESTHETISTS—Nurse; near Chicago; beginning salary $275-$300 with maintenance; 175-bed general hospital; excellent living conditions. MO 58, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETICIAN—Assistant; must be A. D. A. member; teaching and therapeutics; 5-day week; salary open; maintenance optional; position available August 1, 1949. Bushwick Hospital, Brooklyn, New York.

DIETITIAN—Assistant; wanted for 200-bed tuberculosis hospital; good salary plus room, board and laundry; please send small photograph or snapshot with letter of application stating qualifications and pertinent personal details. Apply Superintendent, Indiana State Sanatorium, Rockville, Indiana.

DIETITIAN—Member of ADA to have full charge of dietary department of 300-bed hospital; maintenance furnished if desired; salary open; splendid opportunity. D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIAN—Position open in July, for an accredited dietitian; to manage pay cafeteria for hospital employees in 150-bed general hospital in college town; central Connecticut. For details, write, MO 40, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—Registered; for 165-bed hospital; Omaha, Nebraska; entire new dietary department under construction; good salary. For details, write MO 53, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIANS—One administrative and one therapeutic; fully qualified head of department needed by September 15; growing institution now requires second dietitian with therapeutic duties; 110-bed general hospital near Milwaukee. Apply, Administrator, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIRECTOR—Assistant; in charge of nursing service; immediate opening in 500-bed general hospital with approved school of nursing. Write, E. M. Gerhold, Director of Nurses, Missouri Baptist Hospital, St. Louis, Missouri.

DIRECTOR—Educational; must be experienced; interracial school; salary open; opening immediate; pleasant working conditions in a beautiful city and state. Write to Amelia Trus, Director of Nurses, St. Monica's Hospital, Phoenix, Arizona.

DIRECTOR—Educational; for 465-bed hospital; 189 students in school; college affiliation; beginning salary $4000; retirement plan; requirements, B.S. and M.A. in nursing education and past experience desired. Apply, Director of Nurses, The Reading Hospital, Reading, Pennsylvania.

Continued on page 202

DIRECTOR—Educational; for state approved school of nursing; university affiliation; forty-five hour week; 145 students; 500-bed hospital; post graduate school; generous salary; M.S. or M.A. degree and teaching experience required; position open July or August 1949. Apply to Director of Nurses, St. Francis Hospital, Peoria 4, Illinois.

DIRECTOR OF NURSES—College graduate; complete charge of nursing service, ward housekeeping and personnel in nursing department; opening January 1 in New York State general hospital; 8-hour day, 44-hour week; salary from $3000-$4000 with full maintenance; 2 weeks sick leave and 3 weeks vacation annually; retirement provision; permanent position. Frederick Ferris Thompson Hospital, Canandaigua, New York.

INSTRUCTOR—Assistant nursing arts; position open August 1; degree and experience in teaching preferred; well-organized school of 100 students; salary open. Apply Director of Nurses, Columbia Hospital, Milwaukee 11, Wisconsin.

INSTRUCTOR—Science; salary $250 with complete maintenance; employee insurance plan; attractive comfortable nurses' home facing park; opportunity for study in Baltimore's numerous universities. Franklin Square Hospital, Baltimore 23, Maryland.

WANT ADVERTISEMENTS

POSITIONS OPEN

INSTRUCTOR—Science; for 465-bed hospital and 189 students; school has college affiliation; beginning salary for experience and degree is $3684 with semi-annual increases for three years; hospital has a retirement plan; living accommodations optional; beautiful new nurses' home. Apply, Director of Nurses, The Reading Hospital, Reading, Pennsylvania.

INSTRUCTOR—Clinical; with baccalaureate degree and post graduate course in pediatric nursing. Mount Carmel Mercy Hospital School of Nursing, Unit of Mercy College, 6131 West Outer Drive, Detroit 21, Michigan.

INSTRUCTOR—Science; with degree for accredited school of nursing; average enrollment 50 students; salary based on background and experience; liberal personnel policies including bonus plan. Please communicate with Director of Nurses, The Holzer Hospital, Gallipolis, Ohio.

INSTRUCTOR—Nursing arts; for fall term; 165-bed general hospital; accredited school of nursing; six day week; salary open depending upon qualifications and experience. Apply Director of Nursing, Alexandria Hospital, Alexandria, Virginia.

INSTRUCTOR—Nursing arts; for school connected with hospital of 209 beds; Bachelor's Degree required and experience in teaching; living in or out; salary open. Apply Director of Nurses, Hospital of the Woman's Medical College, Henry Avenue and Abbottsford Road, Philadelphia 29, Pennsylvania.

INSTRUCTOR—Nursing arts; and a Clinical coordinator with degrees; medium size school, pleasant environment, approved personnel policies; salary open. Apply, Director of Nurses, Columbus Hospital, Great Falls, Montana.

INSTRUCTOR OF NURSES—Gross salary $195; maintenance per month; 188-bed hospital; 44-hour week; Clinical Supervisor; for May 1; gross salary $180. Apply, Superintendent of Nurses, General Hospital, Medicine Hat, Alberta, Canada.

INSTRUCTOR OF NURSES—For 140-bed accredited general hospital with training school of 50 students; salary open; 5½ day week; 1 month vacation with pay and statutory holidays; town of 10,000. Apply Superintendent, Aberdeen Hospital, New Glasgow, Nova Scotia.

INSTRUCTORS—Science and Nursing Arts; vacancy September 1, in 130-bed hospital; 32 students; 40-hour week; excellent personnel policies; salary depends on preparation and experience. Apply Director of Nurses, Amsterdam Hospital, Amsterdam, New York.

INSTRUCTORS—Science and Nursing arts; 150-bed accredited hospital; requirements, degree in nursing education desirable, but advanced preparation with experience acceptable; salary based on background and experience; maintenance if desired. Apply, Director of Nursing Education, Laconia Hospital, Laconia, New Hampshire.

LIBRARIAN—Chief medical record; for university hospital; must be registered and experienced in both clinic and private record room operations; must have supervisory ability; general hospital of 400 beds and outpatient department with yearly census of 116,000 visits. Apply, Personnel Department, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, California.

LIBRARIAN—Medical record; for 160-bed hospital in central Wisconsin, city of 30,000; salary open; two medical secretaries to assist librarian. Apply Administrator, Wausau Memorial Hospital, Wausau, Wisconsin.

LIBRARIAN—Record; trained; to open and organize a department of records; state salary expected. Apply Superintendent, Trail-Tadanac Hospital, Trail, British Columbia.

MISCELLANEOUS—Clinical instructor for surgery and Public health nurse for a collegiate nursing program; salary open. Apply Chairman, Division of Nursing, Dillard University, New Orleans 19, Louisiana.

MISCELLANEOUS—Nursing arts instructor; for 350-bed general hospital; eastern Pennsylvania, easily accessible to New York and Philadelphia; degree and experience desired; salary open; evening Assistant director of nurses with one year of college work and experience in administration; salary open; Operating room suture nurses; experienced; salary open; night Obstetrical supervisor; experience and post graduate course; salary open. Apply, Director of Nurses, Lancaster General Hospital, Lancaster, Pennsylvania.

Continued on page 204

WANT ADVERTISEMENTS

POSITIONS OPEN

MISCELLANEOUS—Nursing arts instructor; Educational director; Operating room supervisor, needed at once; immediate opening; good location; State Capitol with many civic advantages; salary open. Apply Director of Nurses, Evangelical Hospital, 6th and Thayer, Bismarck, North Dakota.

MISCELLANEOUS—Nurse science instructor; capable of teaching anatomy and pharmacology for university credit; Operating room nurses preferably with postgraduate work; General staff nurses for obstetrical and communicable disease departments; 44 hour week; differential of $20 for evening duty, $15 for night duty; permanent positions open, also for vacation relief. Apply, Director of Nursing, Evanston Hospital, Evanston, Illinois.

NURSE—Operating room; salary open; also general duty nurses for medical, surgical and obstetrical departments; 50-bed hospital located in university city, central Ohio; vacation; sick leaves and full maintenance allowed. Apply, Superintendent, Jane Case Hospital, Delaware, Ohio.

NURSES—Full or part-time assignments; opportunities for progressive experience in general hospital near university; special surgical program; convenient living quarters and food service in residence hall. Address, Director of Nursing, Mount Sinai Hospital, Cleveland, Ohio.

NURSES—General duty; salary $180-$210, minus $40 deduction for complete maintenance; 44 hour week; employee insurance plan; attractive, comfortable nurses' home facing park; opportunity for study in Baltimore's numerous universities. Franklin Square Hospital, Baltimore 23, Maryland.

NURSES—General duty; for operating room; salary $190, living out, meals and laundry; $180, living in with complete maintenance. Apply, Ethel B. Shettleworth, Directress of Nurses, St. Luke's Hospital, Jacksonville, Florida.

NURSES—General duty; for 430-bed general hospital; 44 hour week; salary, $210, plus $10 bonus for evenings and nights; two weeks' paid vacation and two weeks' sick leave per year; housing available in graduate residence at small cost. Apply Director of Nurses, Good Samaritan Hospital, Portland 10, Oregon.

NURSES—General duty; minimum salary $205; afternoon and night shift differential; automatic periodic increases; sick and annual leave plan; maintenance at nurses' home if desired; building program calling for complete new building started May; located 90 miles south of Sun Valley. Apply Superintendent, Twin Falls County Hospital, Twin Falls, Idaho.

NURSES—Graduate; for 475-bed hospital; salary open. Apply, St. Barnabas Hospital for Chronic Diseases, 183rd Street & 3rd Avenue, New York 57, New York.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Graduate; for general duty in operating room, obstetrical department, medical and surgical floors; modern well-equipped 100-bed hospital; minimum gross salary: $155 per month. Apply, St. Mary's Hospital, Camrose, Alberta.

NURSES—Graduate; wanted immediately. Apply with or forward credentials, to Doctors Hospital Incorporated, 6481 Cote des Neiges Road, Montreal, Quebec.

NURSES—Obstetrical, general duty and delivery room scrub nurses; salary starting at $200; additional for delivery room, evening and night duty; pleasant working conditions. Apply, Directress of Obstetrics, Methodist Hospital, 506 Sixth Street, Brooklyn 15, New York.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay, forty minutes from that city; five day week; salary, $225 per month if post graduate or experienced; $10 additional for evening and night hours; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

Continued on page 206

WANT ADVERTISEMENTS

POSITIONS OPEN

NURSES—Operating room; for 138-bed hospital; 40-hour week; $10 differential for surgery nurses. Apply, Director of Nursing, St. Agnes Hospital, White Plains, New York.

NURSES—Psychiatric; registered nurses with or without psychiatric training are wanted for duty in privately owned psychiatric hospital; salary $165 per month plus complete maintenance; salary is subject to revision upward dependent on experience and qualifications. For further information write Miss Marguerite Harmonson, R.N., Director of Nurses, Timberlawn Sanitarium, P.O. Box 1769, Dallas, Texas.

NURSES—Registered; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

NURSES—Registered; for staff duty, all departments; 165-bed general hospital, six miles south of Washington, District of Columbia, in historic residential city; 5½ day week; base salary $145 per month and full maintenance for 7-3 duty; $25 additional and one meal and laundry living out; $5 additional for 11-7 duty; $10 additional for 3-11 and operating room duty. Apply Director of Nursing, Alexandria Hospital, Alexandria, Virginia.

NURSES—Staff; California hospital on San Francisco Bay; forty minutes from that city; all departments; five day week; salary $215 per month; $10 additional evenings and nights; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Staff; eligible for registration in Michigan, needed for all services in modern 200-bed hospital; salary $216 per month for 44-hour week; 6 months' increase; $10 extra for 3-11 and 11-7 duty; seven legal holidays, twelve days' vacation and ten days' sick leave per year; cafeteria meal service; laundry furnished. Apply Director of Nurses, Pontiac General Hospital, Pontiac, Michigan.

SUPERINTENDENT—Assistant; general hospital; experienced lay administrator for nonmedical functions in 200-bed county hospital; San Mateo county, California; closing date for filing, August 20, 1949; salary range, $415-$519. Apply, Civil Service Commission, San Mateo County, Courthouse, Redwood City, California.

SUPERVISOR—Obstetrical; for 130-bed general hospital; school of nursing, 40 students, 20 beds and bassinetts, obstetrical division; post graduate course and college credits; preferably B.S. desired; 40-hour week; salary open. Write, Director of Nurses, Amsterdam City Hospital, Amsterdam, New York.

SUPERVISOR OF NURSES—Assistant; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry; send photograph; state qualifications and personal details. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

SUPERINTENDENT OF NURSES—Pontiac General Hospital, Pontiac, Michigan. Opportunity to reorganize and improve nursing service as recommended by recent professional survey; applicants should be aggressive and adaptable, have wide background and considerable administrative experience in nursing, and education equivalent to college graduation with courses in nursing administration; salary $3780-$4680 with annual increments of $180; two increases in first year; maintenance available at nominal charges; modern 190-bed plant, large intern-resident program, excellent supporting services, single director; municipal retirement system, liberal sick leave and vacation, tenure under city merit system; educational and cultural opportunities in Detroit one hour away by public transportation. Application blanks furnished on request to Personnel Director, Pontiac General Hospital, Pontiac 18, Michigan.

SUPERVISOR—Obstetrical; 165-bed general hospital, six miles south of Washington, District of Columbia, in historic, residential city; 5½ day week; salary open depending upon qualifications and experience. Apply Director of Nursing, Alexandria Hospital, Alexandria, Virginia.

SUPERVISOR—Operating room; 165-bed general hospital, six miles south of Washington, District of Columbia, in historic, residential city; 5½ day week; salary open depending upon qualifications and experience. Apply Director of Nursing, Alexandria Hospital, Alexandria, Virginia.

Continued on page 208

WANT ADVERTISEMENTS

POSITIONS OPEN

SUPERVISOR—Operating room; for large operating room department of general hospital; experience in operating room management necessary; 44-hour week; liberal vacation and sick leave allowance; salary open depending upon qualifications and experience of applicant. Apply, Director of Nurses, Michael Reese Hospital, Chicago, Illinois.

SUPERVISOR—Pediatric; for 465-bed hospital with 39-bed pediatric department; school has a college affiliation; salary commensurate with preparation and experience; attractive nurses' residence; living in optional; four weeks vacation; 44-hour week; retirement plan. Apply, Director of Nurses, The Reading Hospital, Reading, Pennsylvania.

SUPERVISOR—Pediatric; capable of supervising and teaching students in the care and feeding of well babies in a small hospital for well babies run by the Episcopal organization and located in a city in New York state not far from New York City; ideal position for middle-aged nurse who wishes to get away from the exacting routines of large city hospitals; complete maintenance; satisfactory salary. St. Margaret's House & Hospital, 100 New Scotland Avenue, Albany 3, New York.

TECHNICIAN—Medical laboratory; registration preferred; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry; send photograph; state qualifications and personal details. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

BUSINESS AND MEDICAL REGISTRY
(Agency)
Elsie Miller, Director
553 South Western Avenue
Los Angeles 5, California

ANAESTHETIST—General hospital; 125 beds; Pacific northwest; $300.

ASSISTANT DIRECTOR OF NURSES and clinical instructor—degree, teaching experience required; will also act as assistant to dean of training school of 80 students; southern California hospital; 250 beds; seaside resort city; salary open.

DIRECTORS OF NURSES—(a) For 300-bed Protestant hospital; southern California metropolis; degree and administrative experience required; $3600. (b) County hospital; 45 beds; no training school; located in gold mining region of California; $2900 with maintenance.

GENERAL DUTY NURSES—(a) Nevada hospital north of Las Vegas; $250, maintenance. (b) County hospital; 45 beds; mining region of California; $250, maintenance.

Continued on page 210

BUSINESS & MEDICAL REGISTRY
—Continued

SURGERY NURSE—Postgraduate course or good experience; county hospital; 150 miles northeast of Los Angeles; $275 plus extra for call.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ANAESTHETIST—(a) Near Philadelphia; $350, maintenance. (b) 300-bed Tennessee hospital; $400.

ASSISTANT DIRECTORS OF NURSING—(a) 300-bed modern hospital; mid-west; $325. (b) 250-bed Ohio hospital. (c) 200-bed hospital; New England. (d) 175-bed hospital; west coast; $300.

DIRECTORS OF NURSING—(a) 175-bed hospital; Wisconsin. (b) 125-bed hospital; university city, Texas. (c) 300-bed hospital; Pennsylvania. (d) 150-bed southern hospital. (e) 140-bed hospital; Massachusetts; $300, maintenance. (f) 175-bed hospital; vicinity St. Louis.

DIRECTOR—(a) Nursing service; large nervous and mental hospital; east. (b) Tuberculosis hospital, mid-west. $350.

INSTRUCTORS—(a) Science; collegiate school; mid-western university. (b) Nursing arts; east, mid-west, south; $250-$300. (c) Clinical; $275.

WANT ADVERTISEMENTS

POSITIONS OPEN

INTERSTATE—*Continued*

SUPERVISORS—All services; attractive salaries.

PHYSIOTHERAPISTS—(a) $275. (b) Occupational therapists; west. (c) Pharmacists; $325.

TECHNICIANS—(a) Laboratory; desirable locations; $225-$250, maintenance. (b) X-ray; $225, up. (c) Laboratory-X-ray; $200-$225, maintenance.

RECORD LIBRARIANS—(a) Chief; 350-bed New Jersey hospital. (b) 150-bed Iowa hospital. (c) 125-bed Pennsylvania hospital. (d) 180-bed Virginia hospital. (e) 300-bed hospital; west.

HOUSEKEEPER—(a) 100-bed hospital; Colorado. (b) 325-bed Sisters' hospital; mid-west. (c) 250-bed Ohio hospital. (d) Assistant; New York.

ADMINISTRATORS—(a) 75-bed hospital; central Pennsylvania. (b) 45-bed Ohio hospital, under construction. (c) 90-bed hospital; south central state. (d) 165-bed western Pennsylvania. (e) 85-bed hospital; northwest; school of nursing.

BUSINESS MANAGER—65-bed private hospital; suburb New York; accounting experience.

THE MEDICAL BUREAU
Burneice Larson, Director
Palmolive Building
Chicago 11, Illinois

ADMINISTRATORS—(a) Voluntary hospital, one of larger and more important hospitals, eastern city; considerable charity work; sound business background required. (b) Medical; general, fairly large hospital, fully approved; Pacific coast. (c) Small general hospital to be replaced by new 300-bed institution; fund program and plans completed; building experience desirable; medical man preferred; lay administrator eligible. (d) Woman physician to serve as medical director, teaching hospital. (e) Lay; new hospital, modernly equipped; eighty beds; south. (f) General hospital now under construction; preferably someone experienced in building, equipping, recruiting personnel; east. (g) Voluntary hospital, 250 beds; larger hospital to be completed within two years; preferably one adroit in public relations; town of 125,000, middle west. (h) Small general hospital under construction; completion six-eight months; Oregon. (i) Assistant administrator; Master's in Hospital Administration desirable; 350-bed hospital; building program; middle west. (j) Public relations director and, also, assistant administrator, large teaching hospital; extensive out-patient and research program; former should be experienced in community service; assistant should be medical or lay, nominee or member ACHA. (k) Executive secretary; hospital council; young administrator with working knowledge of accounting and purchasing required; east. MHS-1

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—NURSES—(a) General hospital, 85 beds; town, 15,000, east. (b) Small general hospital; summer resort town, New England. (c) Fairly large general hospital; building program, considerable experience required; middle west. MHS-2

ANESTHETISTS—(a) General voluntary hospital, fairly large size; college town, Pacific northwest; $3600-$4800. (b) Relatively new hospital, 250 beds; group clinic of well qualified specialists in connection; town of 40,000 near university center; southeast; $4200-$4800. MHS-3

DIETITIANS—(a) Small hospital, lake area of Florida. (b) Catering supervisor, men's hall, university; dietitian trained in institutional management required. (c) Chief large hospital, university center; outstanding person required. (d) Home economics department, large food manufacturing company; should be experienced in quantity food cooking, qualified to develop recipes for hotels, institutions; should have fairly wide interest in writing; duties involve some traveling; $4500. (e) Chief; general hospital recently opened under American auspices in South America; knowledge of Spanish desirable; excellent offer. (f) Nutritionist; university appointment; duties consist of consultant service for pediatric and obstetrical patients and conducting clinics in out-state areas; Master Degree desirable. (g) Ph.D. in nutrition; faculty appointment, state university; rank: full professor; teaching research experience required; $5100. MHS-4

Continued on page 212

WANT ADVERTISEMENTS

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSES—(a) Large teaching hospital, university center; east; $6000. (b) Fairly large hospital, 200 students, Chicago area; $5000 maintenance. (c) General hospital opening new addition; seventy students; school affiliated with junior college; fashionable winter resort town; south. (d) General hospital of small size; no training school; all-graduate staff; college town, California. (e) General hospital, 125 beds; new larger hospital under construction; all-graduate staff; college town located in beautiful vacation area; Rocky Mountain state. (f) Collegiate school now being established in connection with large hospital; Master's Degree desirable; large city, Pacific coast. (g) Voluntary hospital, fairly large size; school considered one of leading in California; excellent faculty; $5000-$6000. (h) Administrative assistant and associate director, school of nursing, newly created appointments; co-educational institution; 2200 students, 200 in school of nursing. MHS-5

EXECUTIVE SECRETARIES—(a) State nurses' association; challenging opportunity; headquarters university medical center. (b) Health and hospital division, council social agencies; considerable traveling. MHS-6

FACULTY APPOINTMENTS—(a) Director, advanced program in psychiatric nursing and, also, clinical instructors in medicine, surgery; coeducational institution, 22,000 students, 200 in nursing school; appointments carry full faculty status. (b) Educational director; one of the most important voluntary hospitals in middle west; teaching affiliations; university center; $4000. (c) Science and nursing arts instructors; one of leading hospitals, Chicago area; 40-hour week; salaries $3900. (d) Educational director; teaching unit; 130 students; $4200, university center; southeast. (e) Educational director to establish and conduct program in nursing; liberal arts college; rank: associate or full professor; $5000-$6000. MHS-7

MEDICAL RECORD LIBRARIANS—(a) Supervisor; general private hospital operated by group of physicians; interesting location, California. (b) Assistant; medical school hospitals and clinics; Pacific coast. (c) Chief and, also, assistant; one of leading hospitals, Chicago area. (d) Chief; 500-bed hospital; town, 150,000 near university center; $3000, complete maintenance. MHS-8

MISCELLANEOUS—(a) Social and guidance director; school of nursing, large general hospital, east. (b) Graduate nurse qualified as medical secretary; group appointment, Chicago area. (c) College nurse; coeducational college, 1800 students; well equipped infirmary; private apartment available; south. MHS-9

CLINIC NURSES—(a) Obstetrical, to assist obstetrician, head of department, group clinic; town, 40,000. (b) Surgical, to assist American Board surgeon, chief surgeon, group clinic small hospital; south. MHS-10

PHARMACISTS—(a) Large general hospital; five years' experience desirable; California; $4500-$5700. (b) Large general hospital; New York. MHS-11

Continued on page 214

MEDICAL BUREAU—*Continued*

SUPERVISORS—(a) Pediatrics; new hospital; college town; $4000. (b) Surgical; large teaching hospital; air-conditioned suite; busy department; west. (c) Floor; new hospital, Hawaii. (d) Evening; large general hospital, California. (e) Home for aged; university town, middle west. (f) Obstetrical; new hospital, 200 beds; south; $3600. (g) Psychiatric; small unit, new hospital, California. MHS-12

MEDICAL PERSONNEL EXCHANGE
Formerly
Nurses' Exchange and Placement Service
Nellie A. Gealt, R.N., Director
4707 Springfield Avenue
Philadelphia 43, Pennsylvania

ANAESTHETISTS—General hospitals, Delaware, Florida, Iowa, Montana, Wisconsin; $300, maintenance. Tennessee, eastern Pennsylvania; $350, maintenance.

DIRECTOR OF NURSING—125-bed Virginia; starting $4200; maintenance including apartment.

FACULTY APPOINTMENTS—(a) Health and recreational director; with Degree in Physical Education; R.N. not required; $2400 maintenance. (b) Public health instructor; eastern university staff; Master's Degree required. (c) Science instructor; 115-bed hospital; Puerto Rico; knowledge of Spanish desirable, but not absolutely essential.

WANT ADVERTISEMENTS

POSITIONS OPEN

MEDICAL PERSONNEL EXCHANGE —*Continued*

DIETITIAN—125-bed eastern Pennsylvania; $3000 maintenance.

HOUSEMOTHER—Large coeducational college; good educational background required.

ADMITTING CLERK—280-bed hospital; eastern Pennsylvania.

PHARMACIST—250-bed middlewest; pharmacy new and well equipped.

RECORD LIBRARIAN—Head; 250-bed, general hospital, affiliated with a university department well staffed.

MEDICAL SOCIAL WORKER—General hospital, southern university city.

SUPERVISORS—(a) Operating room; 125-bed New York; $3000 maintenance; must be qualified to teach. (b) Obstetrical; $250-bed general hospital; excellent working and living conditions. (c) Evenings, 3-11; 142-bed New York; $240 meals and laundry. (d) General 40-bed hospital; Wyoming; $2700 maintenance.

TECHNICIANS—(a) Laboratory X-ray; 75-bed Nebraska; $275. (b) X-ray; 275-bed New York; $250.

MEDICAL PERSONNEL EXCHANGE —*Continued*

PHYSICIANS—(a) With or without psychiatric training; $7200 and maintenance for family. (b) Woman university health service; $6000. (c) Resident, 150-bed general hospital; $5000, full maintenance. (d) National pharmaceutical concern; starting $6000 to $8000.

ADMINISTRATORS—(a) Male; small private hospital; knowledge of accounting and business administration required. (b) Assistant administrator to also act as director of nurses; small general hospital graduate staff.

We Make No Charge For Registration.

MEDICAL PLACEMENT AND MAILING SERVICE

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Atlanta, Ga.

ANESTHETISTS—(a) 45-bed hospital; Virginia; salary open. (b) Large hospital; Iowa; salary $300 plus maintenance; one month's vacation at end of first year. (c) Alabama hospital; $275 plus maintenance. (d) Nebraska hospital; salary open. (e) Georgia hospital; $250 plus maintenance. (f) Large hospital; Florida; $250 plus maintenance.

Continued on page 216

MEDICAL PLACEMENT AND MAILING SERVICE—*Continued*

DIETITIANS—Attractive openings in Florida, Alabama, Maryland, Virginia, South Carolina, North Carolina; openings include executive dietitians and therapeutic dietitians.

NURSES—We have numerous openings for graduate nurses in small and large hospitals; Alabama, Georgia, Arkansas, Massachusetts, Texas, Virginia; include clinical instructors, supervisors, superintendents; some call for psychiatric experience.

TECHNICIANS—(a) Laboratory and X-ray; Louisiana; good salary. (b) X-ray; male preferred, capable teaching; salary $250; North Carolina. (c) X-ray and Laboratory; 50-bed hospital; Illinois; male preferred. (d) Laboratory; Alabama hospital; must be registered; $230. (e) X-ray; Texas school. (f) X-ray and Laboratory; Florida hospital; other openings, Georgia, Mississippi, South Carolina, Maryland, Virginia.

SHAY MEDICAL AGENCY

Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATOR West; 250-bed hospital which has just been opened; last word in hospital construction; prefer administrator who has had experience in both business and medical administration; excellent opportunity.

WANT ADVERTISEMENTS

POSITIONS OPEN

SHAY—*Continued*

ASSISTANT ADMINISTRATOR Northwest; 140-bed hospital; background of accounting is preferred; university town of 30,000; $350 to start with, liberal increases provided for.

BUSINESS ADMINISTRATOR Middle west state hospital; prefer man with college degree in hospital administration and some state hospital experience; located in town of 6000 within easy driving distance of two large cities.

SUPERINTENDENT OF NURSES Middle west; 60-bed hospital in industrial town of 12,000 close to large cities; require 3-5 years experience in supervisory capacity; will have supervision of all nursing activities and will also assist the administrator in purchasing hospital supplies and drugs; $3000 plus full maintenance.

DIRECTOR OF NURSES Middle west; degree essential; 130-bed hospital; duties include general supervision of school of nursing and nursing service; sciences are taught at college with which hospital is affiliated; $300 plus full maintenance which includes a three room apartment.

CHIEF DIETITIAN Southeast; 455-bed general hospital, fully approved; modern kitchen and equipment, dietitian will have full charge of department and complete freedom in its management; $3600 plus full maintenance.

SHAY—*Continued*

OPERATING ROOM SUPERVISOR South; 285-bed hospital; $275 plus full maintenance to start; no night calls or Sunday work.

OUT-PATIENT SUPERVISOR Middle west; graduate nurse; 275-bed teaching general hospital; will have to organize and develop generalized and rapidly growing out-patient department; public health or social service background desirable.

WOODWARD MEDICAL PERSONNEL BUREAU
(Formerly Aznoe's)
Ann Woodward, Director
185 North Wabash Avenue
Chicago 1, Illinois

ADMINISTRATORS (a) Lay; university affiliated hospital; requires specialist trained in hospital finance; planning 300-bed cancer research institution. (b) Lay; 150-bed hospital planning new 300-bed building; beautifully situated on Atlantic ocean near famous resort city; southeast. (c) Lay; new, modern 250-bed hospital; western metropolis situated in scenic mountainous region; (d) Lay; 110-bed hospital now being completely reorganized; eastern university metropolis. (e) Lay; 40-bed AOS approved hospital; large OPD, excellent financial condition, situated, beautiful New England rural section. (f)

Continued on page 218

WOODWARD MEDICAL PERSONNEL BUREAU

Lay; excellent 65-bed hospital enjoying reputation of being one of the best smaller hospitals in this southern state; attractive college community of 15,000. (g) Lay; 82-bed, college affiliated hospital; extremely cooperative board; attractive, progressive city situated in beautiful valley surrounded by mountains; west. (h) Lay; small psychiatric private hospital; excellent staff; attractive southern city located in famous blue grass region; purchasing, accounting, personnel relations essential; good salary. (i) Lay; preferably female; new 30-bed hospital under construction; immediate appointment in order to assist in buying; attractive smaller county seat; central. (j) Lay; 50 beds; now under construction; county seat; southcentral. (l) Assistant; lay; with degree in administration and possibly state hospital administrative experience; assume entire control; under supervision, of 1800-bed hospital, farm, dairy and laundry; excellent opportunity obtain further experience large operation.

BUSINESS MANAGER Excellent 100-bed Atlantic coast hospital; summer resort section near New York City.

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Baxter Laboratories, which have the largest production of intravenous solutions and blood transfusion equipment in the world today, use two Frick NEW "ECLIPSE" compressors for cooling the offices, research departments, and many work areas in their recently completed plant at Morton Grove, Ill. This covers 300 by 400 ft. Frick installation made by Midwest Engineering and Equipment Co., Sales Representatives in Chicago. When you want dependable air conditioning, refrigerating or ice-making equipment, engineered to your special needs, look to

Office and Plant are Modern Throughout

One of the Air Conditioned Laboratories

Assembling Expendable Transfusion Sets

Two Frick NEW "ECLIPSE" Compressors

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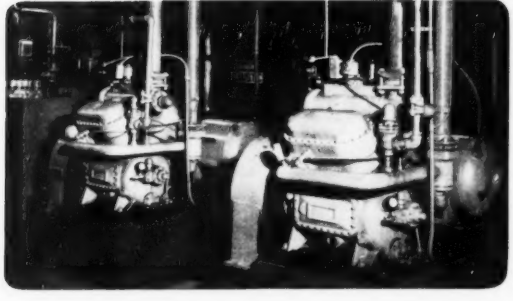

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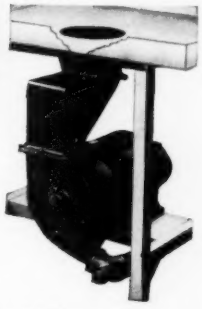
Popular with large and small dishwashing departments. Speeds dishwashing. Saves silverware from loss in garbage. Cuts detergent costs. Helps get dishes cleaner.

WASTEXIT FOOD WASTE DISPOSER



Cuts and discharges all waste into sewer as flowing liquid. Eliminates garbage odor and need of refrigerated storage rooms. Helps solve fly and rat problems. In sizes and voltages to fit your clients' needs.

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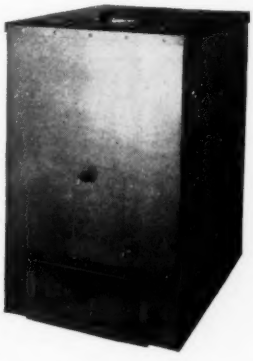

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Continued on page 220

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Continued on page 222

SCHOOLS—SPECIAL INSTRUCTION

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:
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Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

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Classes admitted every other month beginning February. Maintenance and stipend of $75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

WANT ADVERTISEMENTS

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For catalog and terms of tuition address: John C. Allen, M.D., President, 262 Bradley St., New Haven 10, Conn.

SCHOOLS—SPECIAL INSTRUCTION

Skidmore College, in association with the New York University-Bellevue Medical Center of New York University, University Hospital, offers to graduates of accredited schools of nursing, supplementary programs in management and teaching and in operating room technique. Admission dates for seven months' operating room program are the fifteenth day of March and September. Students are admitted for one year program in unit management and teaching the first Monday in October. For details write Director, School of Nursing, 303 East 20th Street, New York 3, New York.

Six months' POST-GRADUATE COURSE IN PEDIATRIC NURSING—Classes begin January, April, July, October—Address inquiries to Director of Nursing, Children's Hospital, 1220 W Street, Northwest, Washington 9, D.C.

Continued on page 224

SCHOOLS—SPECIAL INSTRUCTION

HERRICK MEMORIAL HOSPITAL offers the following programs in the Herrick School of Hospital Arts: 12-month course in Anesthesiology for nurses; 12-month course for Medical Record Librarians; 24-month course for x-ray technicians; 12-month course for practical nurses. Courses G.I. approved or approval pending. For further information, apply to the Director, Herrick School of Hospital Arts, 2001 Dwight Way, Berkeley, California.

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WANT ADVERTISEMENTS

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ST. FRANCIS HOSPITAL, Peoria, Illinois, offers a comprehensive course in Anesthesia to graduate nurses of accredited schools of nursing, and is open to Sisters. This course includes all types and methods of Anesthesia in use today. For further information write to Sister M. Borromea, R.N., Director, School of Anesthesiology, St. Francis Hospital, Peoria, Illinois.

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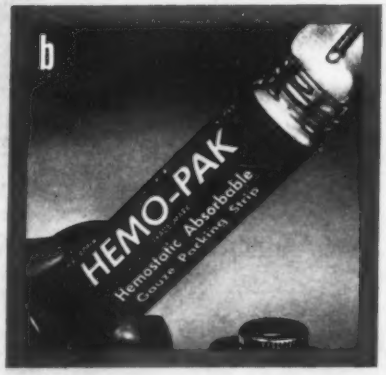

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c ½" x 2½ yds. for postnasal packing following otolaryngologic procedures, and control of spontaneous hemorrhage.

d Uterine packing strips 2" x 3 yds. 4-ply are recommended as replacement for plain or iodoform gauze in cases where uterine packing is required for treatment of uncontrollable post-partum hemorrhage.

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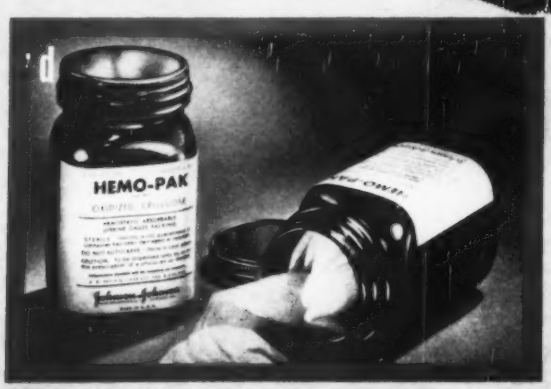
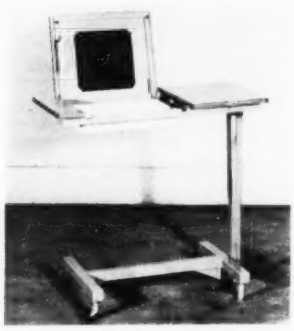


What's New for Hospitals

AUGUST 1949 Edited by BESSIE COVERT

Overbed Table



The new Simmons single pedestal Overbed Table has a simple counterbalanced mechanism which makes the table practically self-adjusting. Known as the F-883, the new table can be easily operated by the patient or the nurse. The upright of the table is grasped firmly on the release section and the table can be raised or lowered easily with one hand and stopped at any desired height from a minimum of 29¾ inches to a maximum of 44¾ inches.

The easily cleaned, 5 ply Formica top is 14½ by 31½ inches in size, thus providing a generous space for all uses. The double acting center section makes it possible for the table to be used from either side of a bed or chair. Features of the table include a large 9 inch square mirror on the underside of the top when tilted away from the patient and a book rest or reading rack when tilted toward the patient; a stainless steel or porcelain tray which can be quickly removed for cleaning and offers a convenient place to keep writing equipment, cosmetics and other personal effects; Simfast enamel, which will not chip, peel or crack, in a variety of colors to match other room furniture; 2 inch ball-bearing casters at the front end to permit easy mobility from room to room and metal glides at the post end for stability when in use. **Simmons Company, Dept. MH, Merchandise Mart, Chicago 54. (Key No. 795)**

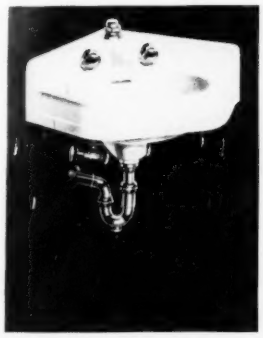
Warming Cabinets

The new Brooklyn electrically heated cabinets have temperature controlled by the new Coben self-contained heating unit which has incorporated a sensitive thermostat directly connected to a mercury switch, thus eliminating open sparking on making or breaking contact. The cabinets are available in both built-in and free standing models and are designed for heating blankets, bedpans, solutions and for drying. They operate on the radiant heat principle, thus eliminating hot spots and dead air pockets, and the very slow circulation of air in the cabinets eliminates movement of lint or dust.

Cabinet bodies and doors are of double wall construction, fully insulated. A dial thermometer is recessed in each compartment door at eye height. Standard sized cabinets are available in 24, 30 and 36 inch widths, 18 inches deep and up to 72 inches high. **Brooklyn Hospital Equipment Co., Inc., Dept. MH, 192 Lexington Ave., New York 16. (Key No. 796)**

Corner Lavatory

The new corner lavatory developed by Crane should be of interest for nurses' homes, personnel quarters, patients' rooms and other places where space is limited. Known as the Vivian, the new lavatory is of vitreous china and is available in colors as well as in white. The overall size is 18 by 18 inches and the basin measures 16 by 11 inches with a depth of 6 inches at the outlet. Dial-ese controls, which utilize the water pressure



to help shut off the flow, are operated by chromium-plated handles. **Crane Co., Dept. MH, 836 S. Michigan Ave., Chicago 5. (Key No. 797)**

Monaghan Portable Respirator

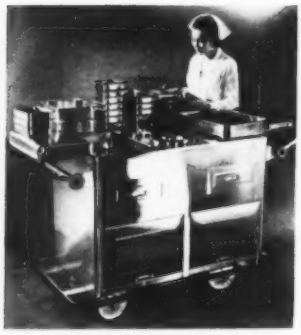
The Monaghan Portable Respirator consists of power cabinet, auxiliary 12 volt battery and light weight plexiglas chest shells. The cuirass type plastic dome fits snugly over the chest and upper abdomen of the patient and is designed to give artificial respiration without enclosing all of the trunk and extremities. Two easily applied elastic straps hold the shell firmly in position and it can be applied and adjusted in a minimum of time. Six plastic shells are supplied with each unit, the shells being graduated in size to accommodate infants, children and adults. The inflatable sealing elements make them universal in application. The unit can be used to treat two patients at the same time, at the same respiratory rate but at different pressures if necessary.

The unit is completely portable and can be operated anywhere at any time. It operates on 110 volt power or on its own self-contained battery to which it switches automatically in case of power failure. The battery can function for 3½ to 4 hours continuously in case of need and when the patient is moved away from electrical outlets as in an ambulance or other mode of transportation. The respirator can also be operated manually if necessary.

The Monaghan Respirator has been accepted by the Council on Physical Medicine of the American Medical Association. It is manufactured by the J. J. Monaghan Company, Inc., of Denver and is distributed exclusively by **The American Hospital Supply Corp., Dept. MH, 2020 Ridge Ave., Evanston, Ill. (Key No. 798)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

Food Conveyor



The new "Selective-Menu" Food Conveyor developed by Blickman is the result of study of the problems involved in accommodating the variety of foods required by hospitals providing selective menus for patients. The flexible top deck arrangement utilizes interchangeable square and rectangular utensils as well as round utensils. A great many top-deck arrangements are possible with the 18 utensils in 6 sizes provided with each conveyor. A long side shelf on the conveyor has room for two complete trays and two heated drawers provide for special diets and rolls.

The top deck is of one-piece construction with wells an integral part of the top, thus making is easy to keep the conveyor clean and sanitary. The body is also of one-piece, seamless construction and the conveyor is built of heavy gauge stainless steel throughout for sanitation, durability and attractive appearance. There are no crevices in the top of the body of the unit where food particles can lodge; thus the conveyor can be cleaned by washing and hosing down with live steam. The conveyor rolls smoothly on large, rubber tired wheels, and the bumper guard protects walls and doorways. **S. Blickman, Inc., Dept. MH, Weehawken, N.J. (Key No. 799)**

Vericon Television System

The use of television for teaching is now possible with the Vericon Television System which was developed for use by the Army during the war and is now being made available for general use in education and business. The system is complete within itself, consisting of the camera or pick-up unit, the pulse-power unit and the master viewer and extensions. Its small size, operating simplicity and the fact that it transmits over a cable rather than through the air make it especially useful in teaching. Since it delivers its impulses over a coaxial cable, there is no need for FCC permission to broadcast. The system needs only to be plugged into any light socket.

Each of the three units of the system is light in weight, compact and completely portable. Once they are connected and initially adjusted the system is entirely automatic. The camera can be mounted in any position, horizontally or vertically, and is easily operated. The master control monitor and viewer has a 42 square inch screen with master controls for remotely operating the camera. The equipment is ruggedly designed to operate continuously over long periods and extension viewers may be hooked up to the master viewer and extended as far as 4000 feet away. Any normal television receiver of the commercial type can be used as an extension monitor.

The Vericon System can be used in any way in which television can serve in teaching. In bacteriology, pathology and similar subjects where the use of a microscope is required a large group of students can observe with the professor whatever is shown on the microscope slide. The use of the Vericon system in the teaching of surgery makes it possible

for a whole class to view the operation at close range through the television screen. Technical and mechanical processes can be demonstrated to a large group or to several classes at the same time through the system with its extension viewers. Similarly, films can be shown over the system to several classes at one time from a central projection room, thus avoiding the necessity for transporting film and projector. The Vericon System offers wired, portable television which should prove of value in the solution of many teaching problems. **Remington Rand Inc., Dept. MH, 315 Fourth Ave., New York 10. (Key No. 800)**

Heinz Jellies

A complete new line of Pure Fruit Jellies has been added to the line of Heinz foods. Eight different fruit flavors are available in the new line: currant, grape, elderberry, blackberry, red raspberry, cherry, crabapple and apple. **H. J. Heinz Co., Dept. MH, 1062 Progress St., Pittsburgh 12, Pa. (Key No. 801)**

Olympic Extractor

A new bottom-unloading Olympic Extractor with basket 54 inches in diameter has recently been announced. Stainless steel is used for basket containers, curb and cover in the new model. Standard equipment includes "V" belt motor drive, air operated safety cover and automatic timer. The new extractor has a capacity of 400 pounds dry weight. **Troy Laundry Machinery Div., American Machine and Metals, Inc., Dept. MH, East Moline, Ill. (Key No. 802)**

Oxygen Humidification Unit

The new LM495 oxygen humidification unit is designed for easy and quick adaptation to any standard oxygen therapy regulator. Consisting of a single stage regulator with clock-type gauges, the new unit has built-in water trap with special diffuser and safety valve which ensures against building up of excessive pressure within itself. **The Liquid Carbonic Corp., Dept. MH, 3100 S. Kedzie Ave., Chicago 23. (Key No. 803)**

Tape Recorder

The new Model No. 8U12 Tape Recordio is a precision built instrument, compactly fitted into a carrying case so that it can be used wherever needed. The unit records original material, records from microphone, radio or telephone and has been used for recording heart beats through a special microphone available for the purpose. It is useful for recording lectures, patient interviews, conferences and for recording operating technics to be used in teaching.

The unit permits a full half-hour of continuous recording with high speed wind in either direction and automatic stop and rewind. Tape can be erased and re-used many times. The unit weighs only 25 pounds and comes com-

plete with a crystal microphone and a spare tape reel. **Wilcox-Gay Corp., Dept. MH, Charlotte, Mich. (Key No. 804)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

Mop Wringer

A small size mop wringer as a companion model to the other wringers in this line, for general purpose cleaning, has recently been announced. Embodying all of the features of the larger Geerpres wringers, the new model is designed to fit any common size of pail or bucket holding 12 quarts or more. The staggered gearing to prevent slip, downward pressure on the mop to prevent splashing, light weight, simple, uniform and fast operation are augmented by rubber grip handle, ribbed pressure plates and electro-plated finish. Known as the No. 816, the wringer is designed to handle any 8 to 16 ounce mop. **Geerpres Wringer, Inc., Dept. MH, Box 658, Muskegon, Mich. (Key No. 805)**

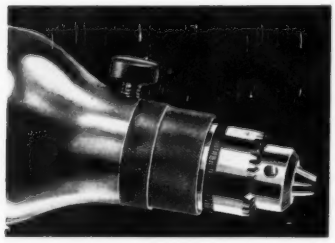
Filter-Cooler

The new Filtrine Filter-Cooler has been especially designed for providing a virtually inexhaustible supply of cold drinking water, with all chlorine taste removed. The integrated Filtrine filter-dechlorinators produce water free from rust, clay and all foreign matter as well as free of chlorine and other taste and odors. High-capacity, automatic refrigerating machine and storage equipment keep the water chilled.

The new unit is ruggedly constructed for hard service and is produced in a wide range of sizes. It is available for cafeteria installation with shelves at top and sides for glasses and racks for standard-sized cafeteria trays. **Filtrine Mfg. Co., Dept. MH, 53 Lexington Ave., Brooklyn 5, N.Y. (Key No. 806)**

Luck Bone Saw

The new Luck Bone Saw has all the features of the earlier model plus Bishop oscillation for use with saws, special tools and burrs where oscillating movement is preferred. A simple shifting mechanism, the construction of which is designed to assure positive locking,



permits change from rotation to oscillation or vice versa. The one precision built instrument incorporates the two features, oscillation and rotation, and distinct markings indicate to the operator which movement is being used. **Zimmer Mfg. Co., Dept. MH, Warsaw, Ind. (Key No. 807)**

Debs "Medi-Kar"

The new Debs "Medi-Kar" is a complete medicine tray on wheels. It is designed for efficient administration of medications with a minimum of time and effort expended by the nurse. It eliminates the need for constantly returning to the central floor station, and obviates the necessity for finding a place for the medication tray in each room.

The removable tray on top of the cart holds 24 medicine glasses, a covered tray, a pitcher for fresh water and 24 water glasses. The convenient drawer at the top holds 12 sterile syringes, either 2 cc. or 5 cc., in a specially designed rack. To avoid error in administering medications, each medicine glass and syringe has its own individual card marker in a permanent holder. The cards provide

for listing the patient's name, room number, medication and other data.

Made of stainless steel with welded construction, the "Medi-Kar" is sturdy, easy to clean and readily mobile with little effort. The stainless steel table section can be used when the medicine tray is removed. The "Medi-Kar" moves quietly and easily and can be brought into the room or left in the corridor as each medication is administered. **Debs Hospital Supplies, Inc., Dept. MH, 118 S. Clinton St., Chicago 6. (Key No. 808)**

Sponge Rubber Mat Backing

Corrugated rubber matting is now available with a sponge rubber backing for longer wear, better traction, easier cleaning and greater comfort. The matting is ¼ inch thick, ⅛ inch corrugated rubber matting and ⅛ inch sponge rubber backing. It is 36 inches wide and is now available in 30 foot rolls. **The B. F. Goodrich Co., Dept. MH, Akron, Ohio. (Key No. 809)**

Electric Compress Heater

The new Ideal Portable Electric Compress Heater was developed and perfected in collaboration with nurses and hospital technicians. It is designed to deliver hot packs, at the desired temperature, at the bedside. It has been thoroughly tested in use to do its work quickly, easily and economically.

The unit relies entirely upon natural physical phenomena with absence of moving parts and complicated operating procedures. It is designed to provide a simple, safe, reliable solution to the problem of providing hot packs and stupes. The temperature of the compresses is under absolute control at all times, according to the manufacturer, and the capacity of the unit is ample for all compresses required for a complete, extensive hot pack treatment. The unit is readily mobile, strong, compact and of stainless steel construction. **The Swartzbaugh Mfg. Co., Dept. MH, 1313 Bancroft St. W., Toledo 6, Ohio. (Key No. 810)**

Watering System for Laboratory Animals

A system for automatic watering of small animals, which has been used by commerical breeders, has been modified and improved to provide an automatic watering system for small laboratory animals. The Hart valve, about the size of the end of a fountain pen, is the basic principle of the system. It is operated by a movement of the point, or teat. When placed at the proper height, water is released through the valve to the animal's mouth at the slightest touch.

The valves are screwed into copper tubes of 23/32 inch diameter at spacings for each cage and the tubing is connected to a vertical tube leading to a pressure break tank maintaining a constant water level at a constant gravity pressure. Water is fed into the tank through connection with the water main. The system has been devised for use with rabbits, guinea pigs, hamsters, rats and other small animals used in the laboratory. **Bussey Products Co., Dept. MH, 6000 W. 51st St., Chicago 38. (Key No. 811)**

Address manufacturers for further information and prices—or use Readers' Service blank on page **232**

Electric Drying Tumbler

An electrically heated tumbler, to meet the needs where other heating facilities are not available, has been added to the line of Zone-Air tumblers developed by American. The new unit embodies the same basic construction and operation features of the steam and gas heated models and completes the line of tumblers offered by the company, making it possible for it to serve the needs of all hospitals, regardless of size or heating facilities. **The American Laundry Machinery Co., Dept. MH, Cincinnati 12, Ohio. (Key No. 812)**

Concealed Door Closer

A new door closer has been announced which provides concealed control for any metal interior door up to 3 feet 6 inches by 7 feet by 1¾ inches in size at a cost which compares favorably with that of an ordinary exposed closer of similar capacity. The closing mechanism is entirely hidden within the top rail of the door and only a slender arm, attached to the frame by a recessed soffit plate, is visible. Violent opening is prevented by a shock-absorber which is standard equipment and a hold-open arm may be specified. **LCN Closers, Inc., Dept. MH, 416 W. Superior St., Chicago 10. (Key No. 813)**

Expendable Intravenous and Infusion Sets

Four new expendable sets, for intravenous solutions and blood or plasma infusions, have been developed by Cutter. Designed to be used once and thrown away, thus ensuring a sterile set for each infusion, the units are equipped with rubber or plastic tubing, with nylon filters included for blood infusion. The expendable Y-tube set, designed for alternating or simultaneous infusion of blood or plasma with intravenous solution, combines the dripmeter and filter into a new single, simplified and sterile administration unit. **Cutter Laboratories, Dept. MH, Berkeley 1, Calif. (Key No. 814)**

Plastic Disc SoundEraser

Plastic discs for dictation and recording can now be re-used 25 times or more. A compact machine about the size of a portable radio, known as the SoundEraser, automatically erases all sound from used discs. The operator places a recorded disc on a spindle, presses a button and in less than a minute the lid of the machine opens automatically and exposes the completely erased disc ready for immediate re-use. **The SoundScriber Corp., Dept. MH, New Haven 4, Conn. (Key No. 815)**

Automatic Justifying Typewriter

The new Underwood Automatic Justifying Typewriter combines the features of the standard Underwood with those of the carbon paper and fabric ribbon attachment machine and incorporates a new built-in feature to provide an even right-hand margin on typewritten copy.

Justifying is accomplished by the new Underwood variable pitch rack which extends beyond the carriage on both sides of the machine. The machine is designed particularly for use in the preparation of bulletins, forms and other material to be reproduced. **Underwood Corporation, Dept. MH, 1 Park Ave., New York 16. (Key No. 816)**

All-Purpose Stove

The new Pyrastove is an all-purpose gas-fired stove providing flexibility, speed, durability and space-saving in one

attractive unit. Field-tested for 18 months, the stove has a new, high-low universal 3 ring burner and a new, efficient combustion and heat distribution system. It offers all speeds from the lowest for the most delicate cookery to high speed for fast or heavy boiling.

The stove is constructed with a 10 gauge steel body, a stainless steel cylinder that directs the heat wash evenly against the fast-heating steel top, 3 continuously welded steel rings with 466 stainless steel parts and separate heat control valves. It is 24 inches high, 22½ inches square, with adjustable legs, ¾ inch machined steel top and 8, 12 and 16 inch openings. The burner, a high speed design, is of the so-called "universal" type, usable with all gases, requiring only an orifice change for high B.t.u. gases. The top, heat distributor, burners, liner and dip tray can be removed from the body of the stove in one minute for easy cleaning. **The G. S. Blodgett Co., Inc., Dept. MH, 50 Lakeside Ave., Burlington, Vt. (Key No. 817)**

Surgical Glove Powder

Bio-Sorb is a new absorbable dusting powder developed as a surgical glove lubricant and for all medical uses. Accepted by the Council on Pharmacy and Chemistry of the American Medical Association, Bio-Sorb powder is compatible with body tissues, thus eliminating any possibility of post-operative adhesions caused by glove powder contamination, and is non-injurious to rubber gloves. A wholly safe cornstarch derivative, Bio-Sorb powder is treated physically and chemically to assure good lubrication after sterilization. **Ethicon Suture Laboratories, Dept. MH, New Brunswick, N.J. (Key No. 818)**

Oxygen Cylinder Carrier

The Samco Oxygen Therapy Cylinder Carrier is light in weight, convenient to handle, will store in a small space and is so constructed as to be easy to clean. The tripod construction, fully automatic, allows the third wheel to swing in or out when the truck is tilted. Swivel caster at rear facilitates steering. A chain lock prevents tanks from tipping forward when loading and all parts are of electrically welded heavy steel wall tubing. **Syracuse Alloy Metals Corp., Dept. MH, 114 S. Salina St., Syracuse 2, N. Y. (Key No. 819)**

Soilproof Wallcovering

The new Glendura Soilproof Wallcovering is designed to resist soiling and to be easily washed clean of soil and stains of all kinds. It is available in a variety of attractive designs and color combinations and is light-resistant, mildew-proof and impervious to fungus and mold stains. It is handled like wallpaper, is soft and pliant, yet strong. The new wallcovering is the result of a new process, developed after many years of research and testing, whereby each pigment particle used in coloring the wallcovering is sealed in a synthetic resin. **Imperial Paper and Color Corp., Dept. MH, Glens Falls, N.Y. (Key No. 820)**

Zeroline Germicidal Lamps

Germicidal lamps are now available to protect foods in walk-in refrigerators, meat and vegetable coolers and other areas where low temperatures are a necessity. Known as Zeroline, the lamps are available in 16 and 30 inch lengths. They are specially constructed for effective operation at near zero temperatures. Life of Zeroline lamps is rated at 8000 hours. **Hanovia Chemical & Mfg. Co., Germicidal Lamp Div., Dept. MH, Newark 5, N.J. (Key No. 821)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

Pharmaceuticals

Cobione

Cobione is the trade mark for crystalline vitamin B_{12} Merck, the antipernicious anemia factor of liver in pure, crystalline form. Clinical studies have demonstrated that Cobione exhibits high hematopoietic activity in pernicious anemia, nutritional macrocytic anemia, certain cases of macrocytic anemia of infancy and in sprue, tropical and nontropical. Saline Solution of Cobione is supplied in 1 cc. ampules. **Merck & Co., Dept. MH, Rahway, N. J. (Key No. 822)**

Chloromycetin

Chloromycetin is a crystalline antibiotic having specific therapeutic activity against a wide variety of pathogenic organisms. Produced synthetically, Chloromycetin shows no variability due to its pure crystalline chemical nature. It is active orally and rectally. **Parke, Davis & Co., Dept. MH, Detroit 32, Mich. (Key No. 823)**

Pentryl

Designed for prompt and sustained relief in hay fever, Pentryl provides a synergistic combination of an antihistaminic and an antiallergic. It is indicated for hay fever, urticaria and other allergic states and is available in two forms: Pentryl in green tablet form for use during the day when the patient is active, and Pentryl Enteric Coated delayed-action red tablets for administration upon retiring. **The Maltine Company, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 824)**

Tripazine

Tripazine is a triple sulfonamide tablet containing no sulfathiazole and designed to minimize crystalluria. Each 0.5 Gm. tablet contains equal amounts of sulfadiazine, sulfamerazine and sulfamethazine. The incidence of crystalluria is markedly diminished by the increased solubility of the triple mixture. **Eaton Laboratories, Inc., Dept. MH, Norwich, N.Y. (Key No. 825)**

Penalev Tablets

Penalev Tablets are designed to provide a new and more convenient dosage form of penicillin for inhalation therapy, sublingual administration, oral use in pediatrics and use in compounding prescriptions. The tablets provide 50,000 units of penicillin free of excipients and binders and are readily dissolved. **Sharp & Dohme, Inc., Dept. MH, Philadelphia 1, Pa. (Key No. 826)**

Product Literature

• **"Fund Raising"** is the cover title of an attractively prepared booklet further titled **"Your Appeal to the Public"** and issued by B. H. Lawson Associates, Inc., Rockville Centre, N. Y. Enlightening information is included on the factors necessary for an appeal to the public, why professional direction is needed, what the professional fund-raiser does and what is expected of you. **(Key No. 827)**

• A completely new 16 page booklet on **"Soap and Soap Equipment"** has recently been published by West Disinfecting Co., 42-16 West St., Long Island City 1, N. Y. The booklet describes the various types of soaps available and gives detailed data on newly-designed, modern, functional soap equipment developed to provide economical and efficient dispensing of liquid soaps. Illustrated with both photographs and schematic diagrams, the booklet should be of interest to administrators and maintenance engineers. **(Key No. 828)**

• A comprehensive study by Sylvania Electric Products Inc., 500 Fifth Ave., New York 18, of the effect of artificial light on color has been reported in a booklet, **"Color Is How You Light It,"** issued by the company. Results of the study furnish a method of determining which of the six different tones of white light now available are best suited to different colors of paints and fabrics. **(Key No. 829)**

• A report of **"Operation Seasickness,"** a clinical study of motion sickness conducted by the United States Army Medical Department in collaboration with the Allergy Clinic of the Johns Hopkins University and Hospital, together with information on Dramamine, the product used in the investigations, is given in an attractive booklet issued by G. D. Searle & Co., Chicago 80. **(Key No. 830)**

• **"Invisible Warmth"** is the title of the attractive 8 page **Bulletin No. 540** issued by The National Radiator Company, Johnstown, Pa. Installation of cast iron convectors concealed by inconspicuous sheet steel enclosures to produce both convected and radiant heat is the subject of the bulletin which gives dimensions, connection data, E.D.R. ratings and roughing-in measurements for all National Aero Convectors. **(Key No. 831)**

• The story of **"Hospital Fund Raising"** is presented in an attractively planned and printed booklet issued by the American City Bureau, 221 N. La Salle St., Chicago 1. Illustrated with line drawings, the booklet carries the sub-title, "A report to our clients and prospective clients" and presents information on the Bureau and its policies. **(Key No. 832)**

• **"Antiseptic Septisol, A New Antiseptic Liquid Soap for Hospital Use"** is the title of an informative booklet recently issued by Vestal Laboratories, Inc., 4963 Manchester Ave., St. Louis 10, Mo. Bacterial aspects of soap, the new antiseptic compound, G-11, and uses of Antiseptic Septisol are some of the subjects covered. The booklet contains a full bibliography on germicidal and antiseptic soaps. **(Key No. 833)**

• Technical data, ratings, measurements and other material on **"Kewanee Steel Boilers for Heating, Power and Process Steam"** are given in the new General Catalog 80, Edition 80N, recently issued by Kewanee Boiler Corporation, Kewanee, Ill. Specifications on the various equipment is supplemented with blueprint type drawings of installations. **(Key No. 834)**

• **"The Tornado Method"** is the title of a new manual of floor care published by Breuer Electric Mfg. Co., 5100 Ravenswood Ave., Chicago 40. The 34 page booklet describes the equipment necessary and the steps to be followed with both old and new floors of every type and composition, from preparation through sealing and finishing to maintenance. A Stain Removal Chart supplements the material. **(Key No. 835)**

• How to achieve long-lasting, attractive hardwood floors and how to maintain them economically and properly is covered in a new illustrated folder, **"Finishing Northern Hard Maple Flooring the MFMA Way,"** issued by the Maple Flooring Manufacturers Assn., 46 Washington Blvd., Oshkosh, Wis. The new folder features timely information on many subjects in the interest of attractive hardwood floors and reviews MFMA research in the development of successful and effective finishes. Other features include information on sanding procedure, tips on the proper application of floor finishes, suggestions for surface cleaning and instructions to builders and engineers. **(Key No. 836)**

• **"A Dream of Green Air . . . ."** is the title of a booklet (Dorex Bulletin 118) issued by W. B. Connor Engineering Corp., 114 E. 32nd St., New York 16, which tells, in narrative style with simple diagrams, some of the problems of air cooling and heating, how a small percentage of odors can make the entire atmosphere objectionable, and how the problem can be solved and money saved. **(Key No. 837)**

• Complete catalog information on the full line of "ShurEdge" cutlery products is given in a new catalog entitled **"Fine Cutlery for Generations"** and issued by Robeson Cutlery Co., Inc., Perry, N. Y. **(Key No. 838)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 232

• The **"Optonic Color Compass"** is designed to assist maintenance engineers, housekeepers and others concerned with painting and decoration in planning, selecting and using color scientifically. It is a color selector wheel which gives 8 different color schemes successfully applied to institutions for securing the full advantages inherent with the proper choice and use of 28 colors for interior painting. The compass outlines four plans for decorating 49 different rooms and is available from The Arco Company, 7301 Bessemer Ave., Cleveland 4, Ohio. **(Key No. 839)**

• The complete line of **"Lyon Steel-Wood Products"** is illustrated in color and described in a leaflet issued by Lyon Metal Products, Incorporated, Aurora, Ill. Specifications, assembly diagrams, construction details, prices and other data on the shelving, lockers, locker racks and cabinets with steel framework and durable hard Masonite parts are included in the folder. **(Key No. 840)**

Book Announcements

The Commonwealth Fund, 41 E. 57th St., New York 22. King and Feldman, "Office Management for Health Workers," 171 pp., $2.25. **(Key No. 841)**

Lea & Febiger, Washington Square, Philadelphia 6, Pa. Hartman and Brownell, "The Adrenal Gland," 581 pp., $12. **(Key No. 842)**

The Livingston Press, 1790 Broadway, New York 19. "Rehabilitation of the Handicapped," 2 vol., 1000 pp., $10 a set, published by the National Council on Rehabilitation. **(Key No. 843)**

W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa. Lichtenstein, "A Textbook on Neuropathology," 474 pp., $9.50. Miller and Hyde, "Gynecology and Gynecologic Nursing," 2nd ed., 485 pp., $4.25. Randall, "Ward Administration," 326 pp., $4. Rathbone, "Corrective Physical Education," 4th ed., 300 pp., $3.75. Routh, "Laboratory Manual of Chemistry," 2nd ed., 98 pp., $1.25. Routh, "Fundamentals of Inorganic, Organic and Biological Chemistry," 2nd ed., 346 pp., $3.25. Weiss and English, "Psychosomatic Medicine," 2nd ed., 803 pp., $9.50. **(Key No. 844)**

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Bessie Covert,
Editor, "What's New for Hospitals"

☐	795 Overbed Table	☐	820 Soil-proof Wallcovering
☐	796 Warming Cabinets	☐	821 Zeroline Germicidal Lamps
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☐	800 Vericon Television System	☐	825 Tripazine
☐	801 Heinz Jellies	☐	826 Penalev Talets
☐	802 Olympic Extractor	☐	827 "Fund Raising"
☐	803 Oxygen Humidification Unit	☐	828 "Soap and Soap Equipment"
☐	804 Tape Recorder	☐	829 "Color is How You Light It"
☐	805 Mop Wringer	☐	830 "Operation Seasickness"
☐	806 Filter-Cooler	☐	831 "Invisible Warmth"
☐	807 Luck Bone Saw	☐	832 "Hospital Fund Raising"
☐	808 Debs "Medi-Kar"	☐	833 "Antiseptic Septisol"
☐	809 Sponge Rubber Mat Backing	☐	834 General Catalog 80
☐	810 Electric Compress Heater	☐	835 "The Tornado Method"
☐	811 Watering System	☐	836 "Finishing Maple Flooring"
☐	812 Electric Tumbler	☐	837 "A Dream of Green Air"
☐	813 Concealed Door Closer	☐	838 Cutlery Catalog
☐	814 Intravenous and Infusion Sets	☐	839 "Optonic Color Compass"
☐	815 Plastic Disc SoundEraser	☐	840 "Lyon Steel-Wood Products"
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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc. 919 N. Michigan Ave., Chicago 11, Ill.

Suppliers' News

Baybank Pharmaceuticals, Inc. announces that in future all orders for "Vaseline" Sterile Petrolatum Gauze Dressings should be addressed to the parent organization, **Chesebrough Mfg. Co., Cons'd (Professional Products Div.), 17 State St., New York 4.**

Hard Manufacturing Co., Buffalo 7, N. Y., manufacturer of hospital beds and furniture, announces the election of James G. Dyett to succeed his father, James H. Dyett, as president of the company. The company has also been appointed national distributor for Dunlop Pillo-Foam latex foam hospital products manufactured by **Dunlop Tire and Rubber Corp.,** also of Buffalo.

Johns-Manville Corp., 22 E. 40th St., New York 16, manufacturer of building materials, announces the opening of the **Johns-Manville Research Center at Manville, N.J.,** on May 24, 1949, "Devoted to raising living standards and creating jobs . . . To service through science for better homes and greater industrial efficiency . . . To providing more and better things for more people."

J. T. Posey Co., manufacturer and distributor of orthopedic equipment, announces change of address from 1503 Gardena Ave., Glendale 4, Calif., to **234 E. Colorado St., Pasadena 1, Calif.**

U. S. Gutta Percha Paint Co., Providence, R. I., manufacturer of paint products, announces opening of new Chicago office and warehouse at **417 W. Ohio St., Chicago 10.**

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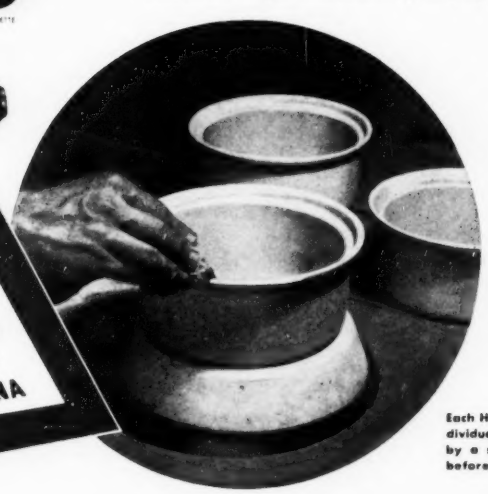
PREFERRED
for CASSEROLE COOKERY



The chef who takes pride in his recipes knows that the full flavor is preserved if preparation and serving is done in Hall ware. Hall China lasts longer . . . cannot absorb . . . is easy to clean . . . keeps its fresh new look permanently. It is the only china made by our single-fire process which inseparably fuses body, glaze, and color.

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Each Hall Casserole is individually hand finished, by a skilled craftsman, before glaze is applied.

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In THE SHAMROCK HOTEL, Houston, Texas, every detail of facilities and service is the reflection of one dominant standard—*"Only the best!"* No two rooms are alike. All furnishings are luxurious and were specially designed. Each guest room has individual air conditioning. Each is equipped for its own television receiver. From the entrance to rear doors you'll find distinguishing features. They even store the garbage in a refrigerated room!

The Shamrock *is* a hotel of surprises, but it's no surprise to know it is completely equipped with SLOAN ROYAL *Quiet Flush* VALVES. These modern flush valves scientifically eliminate noise. The sound of rushing water is silenced to a murmur, thereby protecting guests against unnecessary annoyance. With Sloan Flush Valves, The Shamrock adheres to its rigid standard of *"Nothing but the best."*

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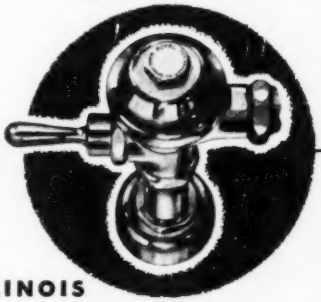

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